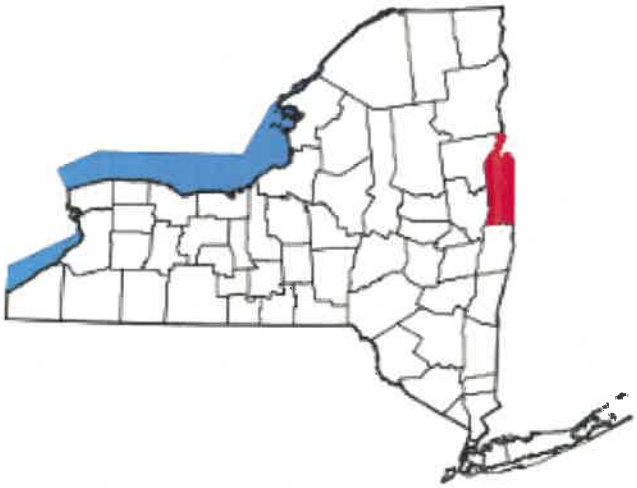

2019-2021 Community Health Assessment and Community Health Improvement Plan

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Introduction

Washington County is in Northeastern New York and is bordered by Warren and Saratoga Counties to the west, Essex County to the north and Rensselaer County to the south. Washington County shares its eastern border with the State of Vermont. Washington County has seventeen towns and nine villages and is part of the Glens Falls Metropolitan Statistical Area (GF/MSA).

With a total area of 837 square miles, the county has a population density of 74 persons per square mile. A little over one third (36%) of the total square miles is designated as farmland. The total population of the County is 62,183. Residents are quite homogenous as 98.5% of the population is white, non-Hispanic, 3.4% are Black, non-Hispanic and 2% consider themselves Hispanic or Latino. One half percent of the population is Asian, Pacific Islander, non-Hispanic, and 0.2% of residents are Alaskan/ American Indian.

The Town of Fort Edward, which serves as the county seat is considered the halfway point between Montreal and New York City. Located inside the Adirondack Park, the northern most portion of Washington County is primarily mountainous & forested. Gentle rolling hills and flatlands traditionally developed as farmland are characteristic of the bucolic southern and eastern landscape of the county. Just a short commute to the cities of Saratoga Springs, Glens Falls, Bennington, Rutland and New York's Capital District, the County is convenient. Major lakes and rivers form much of the county's border. The Hudson River runs along the county's southwestern perimeter, while Lake George and Lake Champlain rim the northern edge. The Poultney River forms the northern portion of the county's border with Vermont. The Champlain Canal traverses the county from the Hudson River at Fort Edward, northeast to Whitehall at the headwaters of Lake Champlain.

Environmental diversity is Washington County's greatest asset. Whether your preference is for lakeside living, rural village life or the rustic charm of the Adirondack Mountains, Washington County has it all. You are never far from all the amenities that city living can offer. Boston, Montreal and New York are all within a few hours' drive. The New York State Capital District, which includes the city of Albany, is an easy commute from southern Washington County. The county offers homes in traditional village and rural settings, as well as modern suburbs. Well-established neighborhoods in both urban and more traditional farming communities have homes representing various historic eras and architectural styles, as well as newer single-family homes, apartments and townhouses. There is a strong tradition of home ownership in the county.

Washington County offers its residents "the good life in the great outdoors." The county is rimmed by miles of recreational waterways. The region has literally thousands of lakes and ponds, as well as miles upon miles of brooks, streams and trails. Some of Washington County's notable waterways and lakes include the Hudson River, Lake George, Lake Champlain, the Champlain Canal, Cossayuna Lake, Summit Lake, Lake Lauderdale, Pine Lake, Lake Nebo, and Hadlock & Copeland Ponds. The Battenkill, Poultney and Mettawee Rivers are renowned for

trout fishing. The Washington County region offers a wide variety of outdoor recreational activities year-round. The MSA (Warren and Washington Counties) was recently rated the number two best golfing area in the nation by "Golfing Digest." Visitors and residents alike may also enjoy horseback riding, camping, picnicking, hiking, mountain biking, hunting, fishing, ice fishing, water-skiing, parasailing, scuba diving, downhill & cross-country skiing, ice skating, snowmobiling, snowshoeing, motorized boating, canoeing, kayaking & rafting. The northern most portion of the county is in the Adirondack Park. The Adirondack Park is the largest park in the lower 48 states and the largest wilderness area east of the Mississippi River. Totaling six million acres, the park's land area is equal in size to the state of Vermont. With over 2,800 lakes & ponds, over 30,000 miles of brooks and streams and 1,200 miles of river, the Park offers countless recreational opportunities for visitors and residents. For hiking enthusiasts, there are more than 2,000 miles of trails and forty-six peaks. The Park is home to the Village of Lake Placid, the winter sports capital of the Northeast and the host of two Winter Olympics.

Modern transportation facilities have contributed to the economic growth of the county. The trade corridor between Canada and New York possesses an advanced transport infrastructure that includes fully modernized rail access to much of North America. Canal access to the Atlantic coast and Great Lakes is provided by the Champlain Canal, and an interstate highway system connects the regions businesses and industry to the entire North American Continent. This area is part of the Champlain–Hudson Gateway and Trade Corridor, providing the critical transportation links between Canada and the U.S. The corridor is becoming more than a growing commercial route — it has become a bi-national economic region. As one of the most important such corridors in North America, the Montreal to New York City connection is critical to the economies of both countries. (Washington County Data Book)

The purpose of this Community Health Assessment (CHA) is to identify and prioritize the health care challenges currently faced by the residents of Washington County. The findings in this assessment result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. The results of this assessment are intended to help members of the community, especially healthcare providers and Community service providers, work together to provide programs and services targeted to improve the overall health and wellbeing of all residents of Washington County.

Working within the framework provided by New York State's Prevention Agenda 2019-2024, Glens Falls Hospital and Washington County Public Health collaborated in the development of this CHA/CHNA. Additionally, Washington County Public Health participated in regional health assessment and planning efforts conducted by the Adirondack Rural Health Network. The Community Health Assessment was developed from a systematic mining and assessment of both primary and secondary data collected by the Washington County Public Health Nursing Service in conjunction with its partners the Adirondack Rural Health Network, Glens Falls Hospital and the Washington County Healthy Communities Coalition. This report is derived through the evaluation and thoughtful analysis of a plethora of data, experience and input from a wide range of stakeholders including professionals from health care, social services, education, and government institutions as well as community members in Washington County.

The Adirondack Rural Health Network (ARHN) is a strategic partner-driven, seven-county region rural health network, that supports the NYS Prevention Agenda through advocacy, education, collaboration, training, funding, and data sharing to improve the health and well-being of our rural residents. Since 2002, ARHN has been coordinating regional collaborative community health assessment and planning efforts of public health departments and hospitals in the seven county Adirondack region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of 13 hospitals and county health departments, from seven counties, that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, The University of Vermont Health Network - Alice Hyde Medical Center, The University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, The University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health. This multi-county, regional committee has been meeting in person every three months throughout the last assessment and planning cycle and will continue to do so during the 2019-2021 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections if needed. To engage the broad community, the CHA Committee created a list of 807 community stakeholders, including professionals from health care, social services, educational, and governmental institutions as well as community members. A stakeholder survey, developed by the CHA Committee to garner constructive feedback, was sent to the 807 identified stakeholders and was comprised of 14 community health questions and several demographic questions. The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The survey summary provided a regional look at the results through a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provided individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. The results enable the CHA Committee to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.
Community Health Assessment Committee

The Community Health Assessment (CHA) Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda. Since 2002, ARHN has coordinated the CHA Committee providing a resource for collaborative formal community health planning throughout the region.

CHA COMMITTEE:

CLINTON COUNTY
Clinton County Health Department
UVMHN-Champlain Valley Physicians Hospital
ESSEX COUNTY
Adirondack Health
Essex County Health Department
UVMHN-Elizabethtown Community Hospital
FRANKLIN COUNTY
Franklin County Public Health
UVMHN-Alice Hyde Medical Center
HAMILTON COUNTY
Hamilton County Public Health
FULTON COUNTY
Fulton County Public Health
Nathan Littauer Hospital and Nursing Home
WARREN COUNTY
Glens Falls Hospital
Warren County Health Services
WASHINGTON COUNTY
Washington County Public Health Service.

GUIDING PRINCIPLES FOR THE COMMUNITY HEALTH ASSESSMENT (CHA) COMMITTEE:

• To the best extent possible, committee decisions are developed through an informal organic process resulting in group consensus;
• Voting is used when necessary to help move discussion toward a final decision: o Any committee member can request that a vote be taken on a topic under discussion; o Voting is conducted confidentially; Each member organization has one vote, cast by the organization's designated representative; Voting can be delayed and/or conducted electronically when it is essential to have input from members not in attendance at a meeting where a vote is requested;
• Committee members keep an eye on what is happening in the wider health care network to ensure an appropriate context for committee decision-making;
• Committee operations are conducted efficiently and in a manner that is sensitive to the needs and concerns of committee members.

CHA COMMITTEE, AD HOC DATA SUB-COMMITTEE: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA)/ Community Health Needs Assessments (CHNA), as well as identify ways to enhance the Community Health Improvement Plans (CHIP)/Community Service Plans (CSP)

process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey. Data Sub-committee members concluded the process would be enhanced by:
• Documenting (quantitatively and qualitatively) the impact of social determinants of health on the primary health outcomes and priorities selected by the CHA Committee members; and
• Strengthening CHA members' ability to foster community stakeholders' understanding of the primary health outcomes in their county/region and to enlist stakeholders' active participation in activities to improve those outcomes. The sub-committee identified the following items to focus on to achieve the outcomes noted above:
• Analyzing and interpreting community health assessment data;
• Engaging stakeholders to solicit feedback on priorities and sharing results of the CHA/CHNA/CHIP/CSP with stakeholders;
• Collecting information about the social determinants of health and "changing environment" that impacts the region's health;
• Identifying assessments conducted by other community sectors/organizations that may help inform and enhance the processes used in the previous cycle;
• Revisiting the tool and process designed to assist in the identification of health priorities; and
• Identifying opportunities to strengthen local health departments' ability to meet Public Health Accreditation standards regarding the community health assessment and planning process.
Summary of Issues Addressed by the Data Sub-committee:
• Developing a 2019 Stakeholder Survey;
• Incorporating a Social Determinants of Health perspective into the 2019 Community Health Assessment process;
• Reviewing processes and tools used to identify health priorities;
• Identifying criteria that could be used to assist in the prioritization process;
• Reviewing methods for community engagement in the community health assessment and health improvement activities; and
• Utilizing community asset mapping as a component of the community health assessment and community health improvement/community service plan efforts. New York State Prevention Agenda 2019-2024 The Prevention Agenda Action Plans provide communities with recommended evidence-based interventions, promising practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities and support healthy and active aging.
The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity in all populations who experience disparities. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public Health and Health Planning Council at the request of the Department of Health. This is the third cycle for this statewide initiative. New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach, initiated in 2017, which calls on all state agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support New York's commitment as the first age-friendly state. The Prevention Agenda 2019-2024 has five priorities with individual priority-specific

action plans developed collaboratively with input from community stakeholders, as shown below. Each priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities. These objectives are tracked on the New York State Prevention Agenda Dashboard: http://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

The New York State Prevention Agenda 2019-2024 Priority Areas:

According to the New York State Prevention Agenda 2019-2024: An Overview, the prevention agenda serves as the State's health improvement plan. This is a guide for state and local actions to improve the health and well being of all residents of New York and work to improve health equity in the population and for those who experience health disparities. The current priority areas and agenda are the third cycle of priority setting which began in 2008.

The Prevention agenda is based on a statewide assessment of health status and disparity data, changing population demographics and a study of the underlying causes of death and disease in NY. The primary goal of the Prevention Agenda is to encourage public health approaches which improve the health and well being of the entire population with a special focus on the drivers of poor health, disparity and health inequities. The social determinants of health are important conditions in the environments in which people live, learn, work, play, worship and are born and age. They have been proven to have a wide range of health and quality of life effects which must be considered in any plan for population health improvement.

The current priority areas are described below:

Prevent Chronic Disease

Focus Area 1 Healthy Eating and Food Security
Focus Area 2 Physical Activity
Focus Area 3 Tobacco Prevention
Focus Area 4 Preventative Care and Management

Promote a Healthy and Safe Environment

Focus Area 1 Injuries, Violence and Occupational Health
Focus Area 2 Outdoor Air Quality
Focus Area 3 Built and Indoor Air Environments
Focus Area 4 Water Quality
Focus Area 5 Food and Consumer Products

Promote Well-Being & prevent Mental & Substance Use Disorders

Focus Area 1 Well Being
Focus Area 2 Mental and Substance Use Disorders Prevention

Promote Healthy Women, Infants and Children

Focus Area 1 Maternal and Women's Health
Focus Area 2 Perinatal and Infant Health
Focus Area 3 Child and Adolescent Health
Focus Area 4 Cross Cutting Healthy Women, Infants and Children

Prevent Communicable Diseases

Focus Area 1 Vaccine Preventable Diseases
Focus Area 2 Human Immunodeficiency Virus (HIV)
Focus Area 3 Sexually Transmitted Infections (STIs)
Focus Area 4 Hepatitis C Virus (HCV)
Focus Area 5 Antibiotic Resistance and Healthcare-Associated Infections

Washington County Data Overview and Analysis:

***Please note all rates are per 100,00 unless otherwise specified.**

Overview/Abstract:

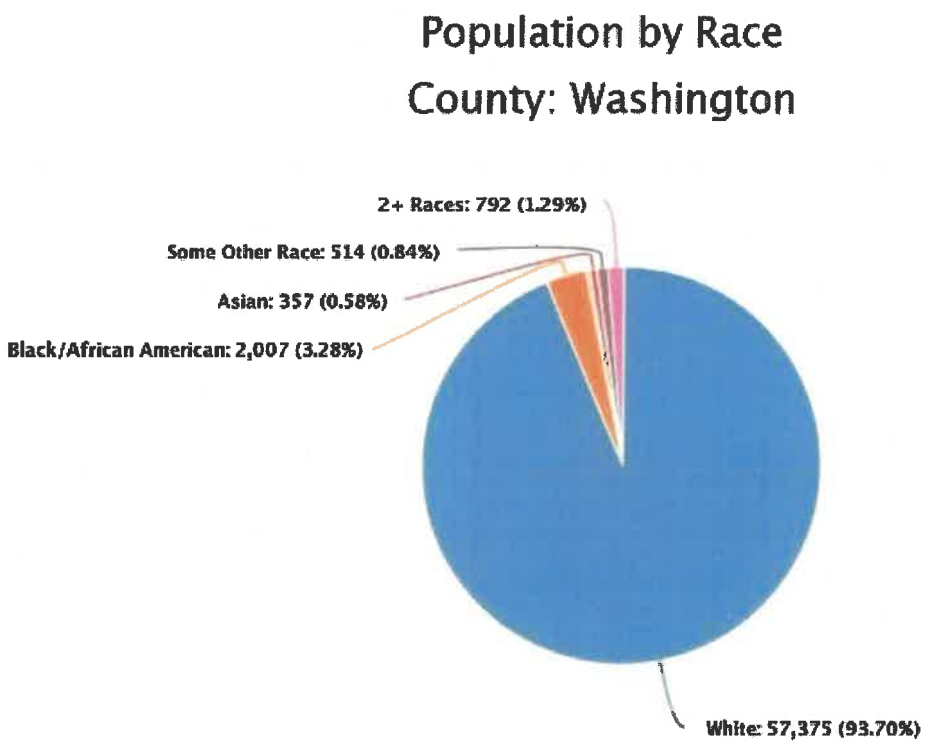
The Adirondack Rural Health Network (ARHN) region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. There are health professional shortage areas within the county, resulting in significant disparities in access to care, however, the population with low-income and low access to supermarkets is lower than the ARHN region and Upstate New York.

Demographics:

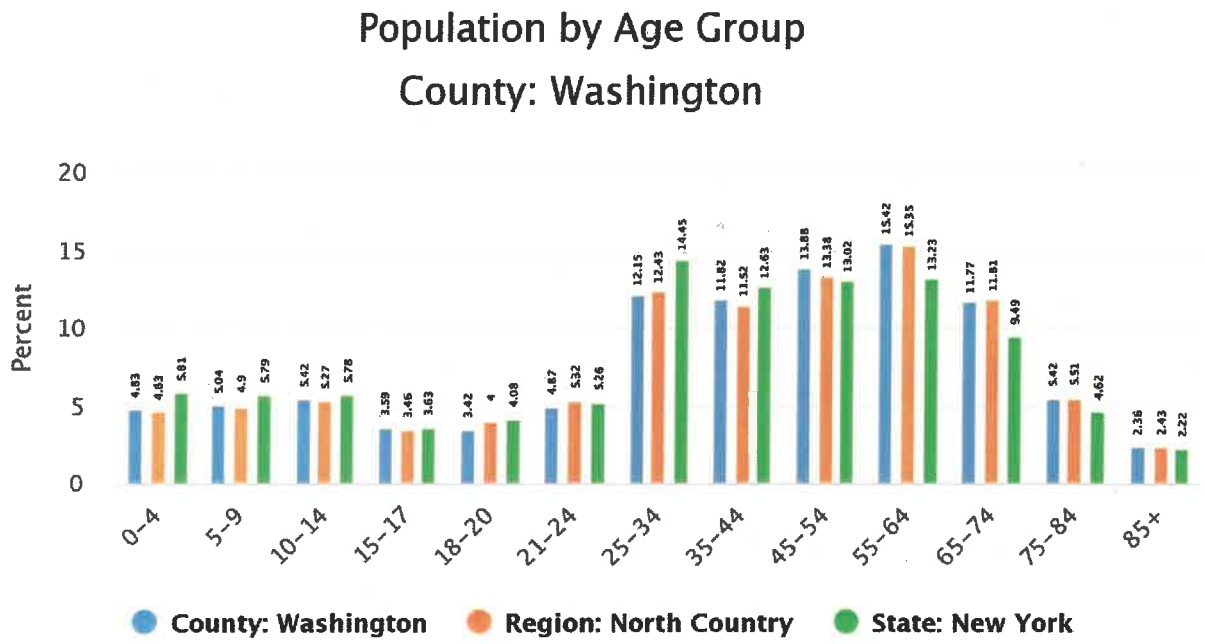
Washington County's population is 62,183. Similar to the rest of Upstate New York, Washington County's population is very limited in its diversity, over 93% are White/non-Hispanics, followed by 3.4% Black/African American, non-Hispanics and 2.6%

Hispanic/Latinos. Over 17% of the population is 65 years of age and older, which is slightly lower than the ARHN region (18.0%) yet higher than Upstate New York (16.37%).
Of note, between 2016 and 2017 the population of Washington County declined form 62,465 persons to 62,183 persons, a 0.45% decline. This mirrors the state population decline, which continues at a rate faster than any other state in the Country.

Washington County is rather homogeneous by race with 93.7% of the population reported as White. There have been noted increases in other races that command attention and study as the County becomes more diverse.



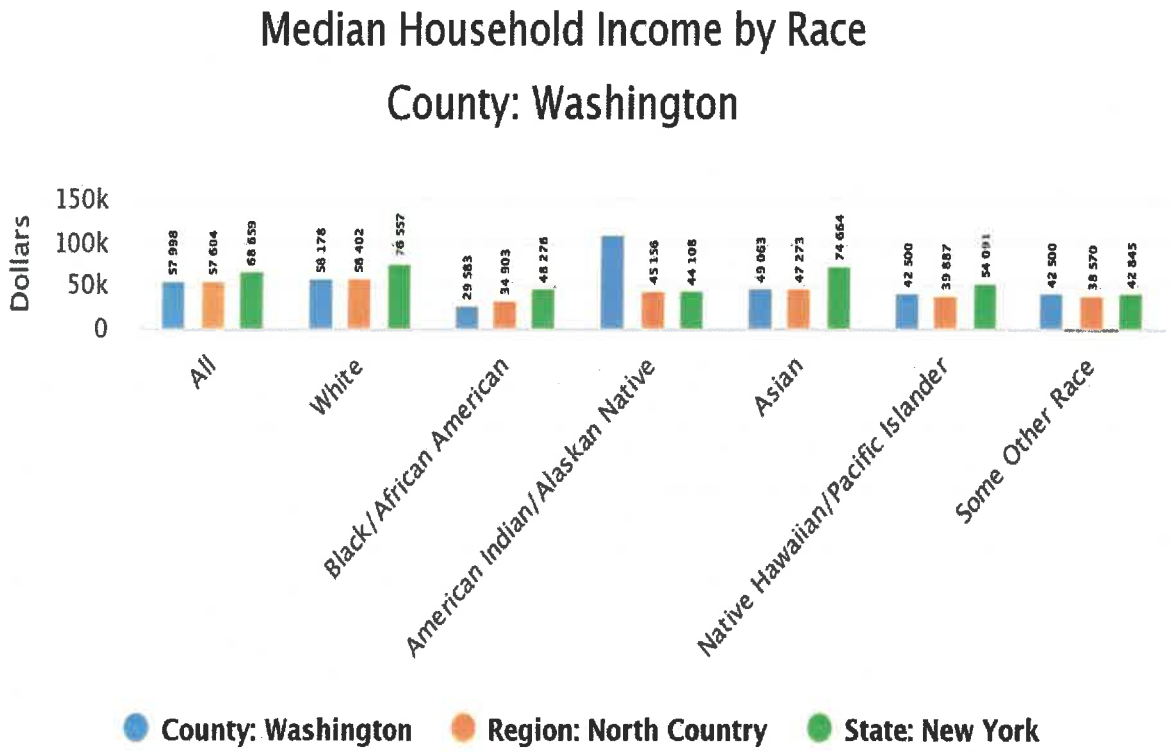
Claritas, 2019. www.healthyadk.org



Claritas, 2019. www.healthyadk.org

The County population is aging rapidly as this graph depicts a top-heavy distribution by age. Bulging at the 25-74 age range. The younger ages are not growing at a rate high enough to replace those who are aging. This demonstrates a slowing of the growth of the population and a larger burden of aging individuals and the needs that typically come with that age group. This coupled with the out migration of the population will require continued assessment as health care capacity and access to services has been identified as issues in the health care continuum.

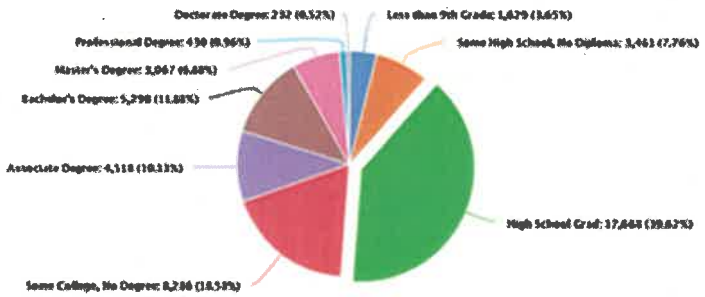
Household income on average is $65,798, with per capita income at $26,064, which is much lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Washington County living below the Federal Poverty Level is 12.8%, which is lower than the ARHN (13.9%) region and higher than Upstate New York (11.7%). In Washington County, the unemployment rate is 3.9%.



Claritas, 2019. www.healthyadk.org

Educational Attainment:
Of the total population in Washington County, approximately 39.2% of individuals 25 years of age and older have a high school diploma or equivalent, and another 30.5% have an Associates or bachelor's degree or higher. Sixty percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (23.0%), followed by retail trade (14.3%), manufacturing (14.0%), and arts, entertainment, recreation, hotel & food service (7.8%).

Population 25+ by Educational Attainment
County: Washington



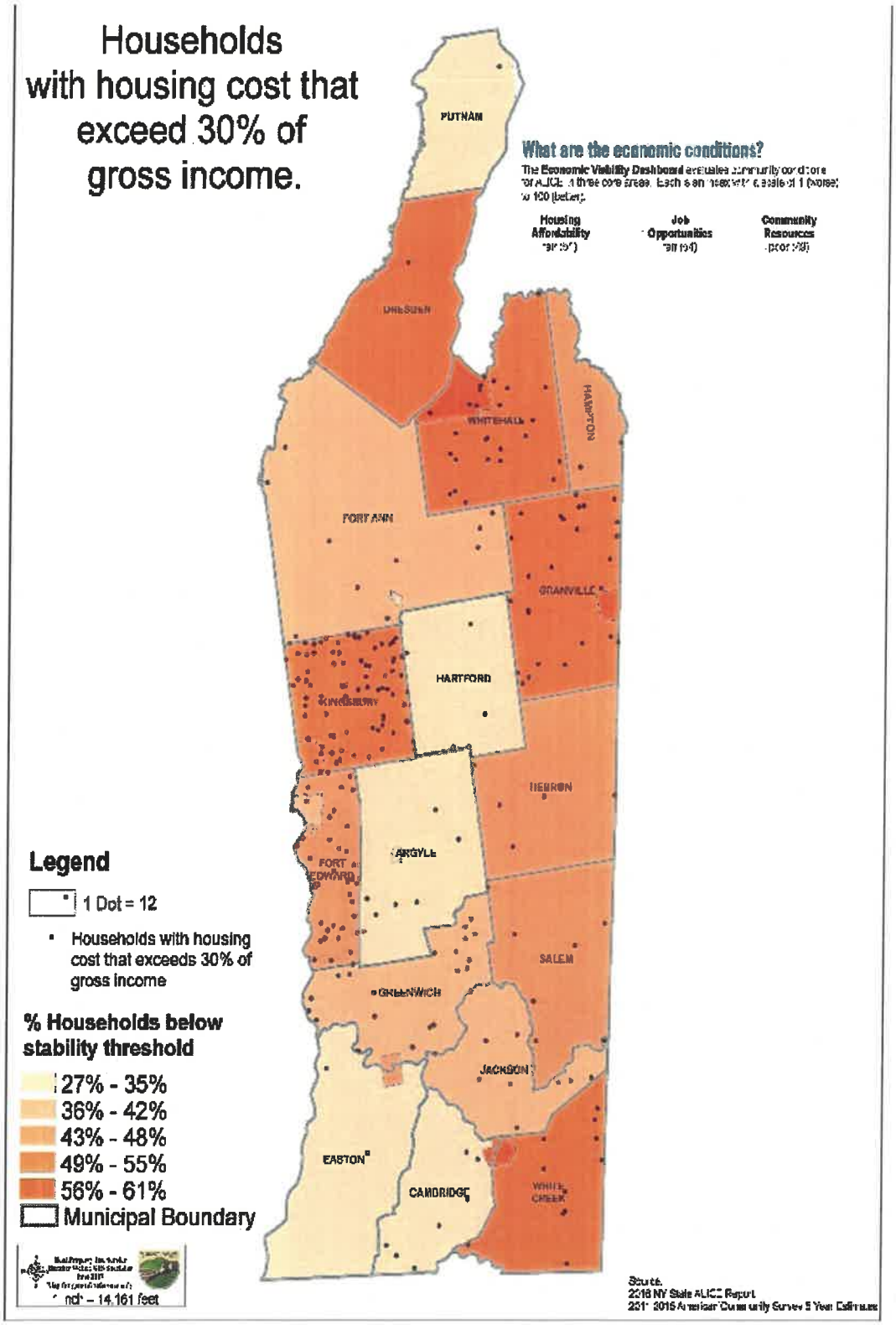
Claritas, 2019. www.healthyadk.org

Population 25+ by Educational Attainment	Washington		North Country		New York	
	Persons	%	Persons	%	Persons	%
Less than 9th Grade	1,629	3.65%	9,505	3.71%	893,096	6.44%
Some High School, No Diploma	3,461	7.76%	20,293	7.93%	1,025,310	7.40%
High School Grad	17,668	39.62%	93,019	36.34%	3,646,775	26.30%
Some College, No Degree	8,286	18.58%	49,233	19.24%	2,196,618	15.84%
Associate Degree	4,518	10.13%	28,038	10.96%	1,200,911	8.66%
Bachelor's Degree	5,298	11.88%	30,563	11.94%	2,775,799	20.02%
Master's Degree	3,067	6.88%	19,887	7.77%	1,528,791	11.03%
Professional Degree	430	0.96%	3,318	1.30%	390,170	2.81%
Doctorate Degree	232	0.52%	2,079	0.81%	206,274	1.49%

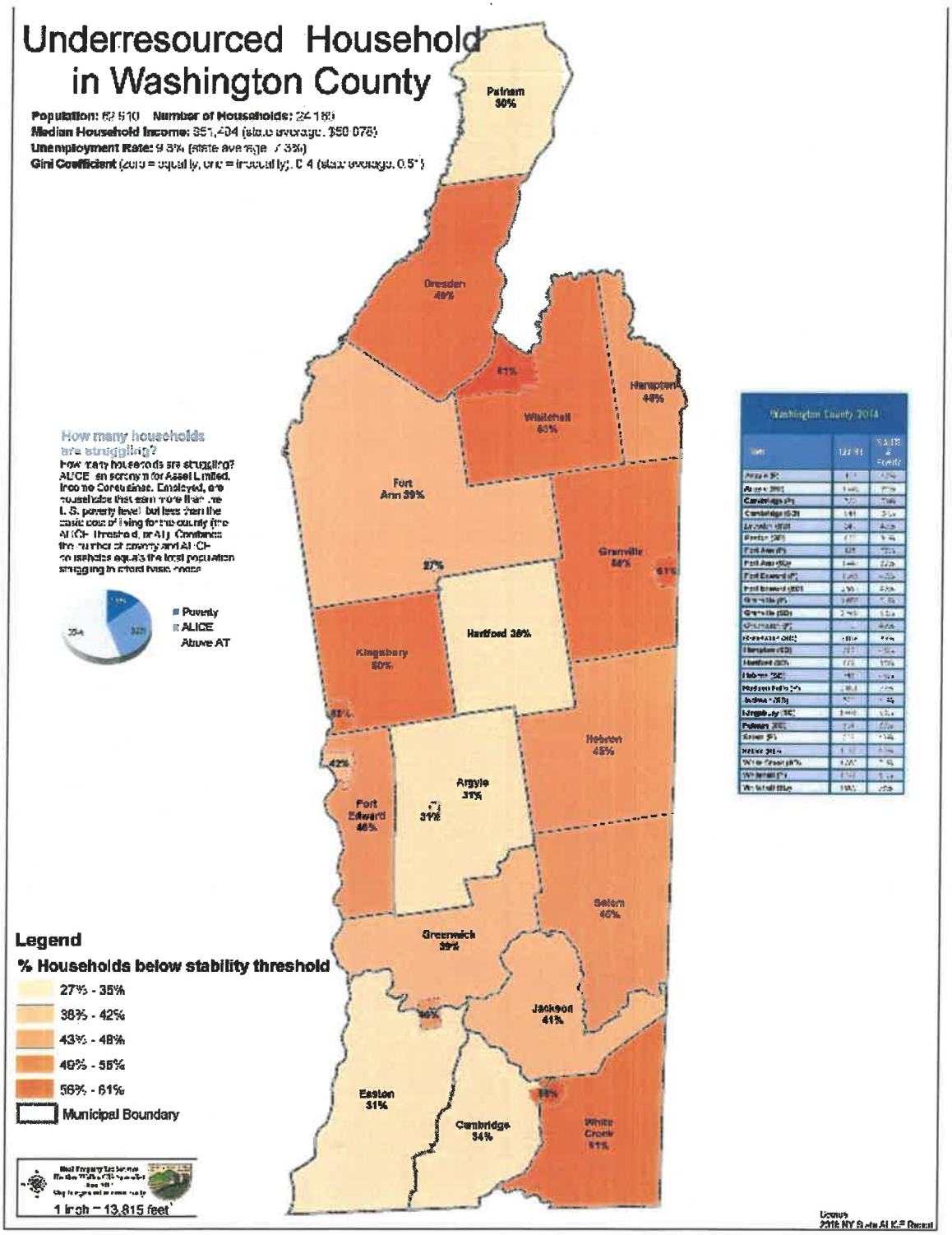
Health System Profile:
There are total of four nursing home facilities, accounting for 528 beds, and four adult care facilities, accounting for 142 beds, with rates of 849.1 and 403.6, respectively. The rate of primary care physicians in Washington County is 66.4, with a total physician rate of 81.4. Washington County consists of 4 health professional shortage areas (HPSAs), one in primary care, one in dental care, and two in mental health.

Education Profile:
Within Washington County, there are 12 school districts, with a total enrollment of 8,655 students. Of the enrolled students, 48%, nearly half, are eligible for free and reduced lunch, with majority eligible for free lunch (88% or 3,511). The total number of high school graduates is 563 with a dropout rate of 4.0%, which is significantly higher than the ARHN (0.8%) region, Upstate New York (0.64%) and New York State (3.0%). There are 10.8 students per teacher in Washington County, which is comparable to ARHN region but slightly lower than Upstate New York (12.37).

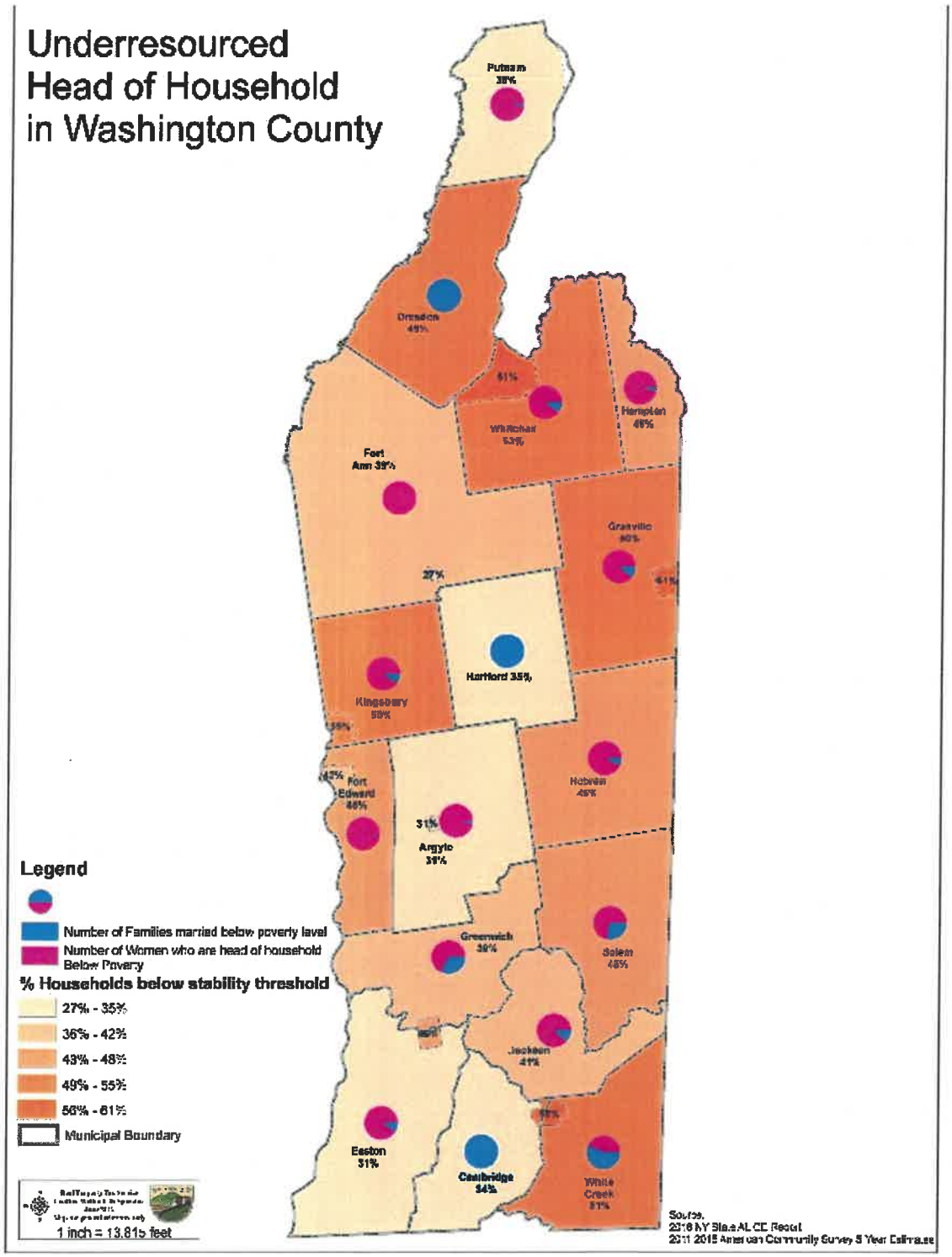
Asset-Limited, Income-Constrained, Employed (ALICE) Profile:
In total, there are 24,027 households in Washington County, with approximately 28% of residents over 65 years of age. There is a 12.1% poverty rate and 30.4% ALICE rate, with a total of 10,204 households designated as either poverty or ALICE. Specific to ALICE households, the majority are white (7,404), which far exceeds the second largest group of ALICE households comprised of Hispanic individuals (200). The ALICE delineated group is a particular concern as it represents families and individuals who work, but whose salaries do not provide sufficient resources to meet basic needs. They often do not qualify for assistance or services due to employment and income just over allowable thresholds. This is a growing aggregate of young and old who need engagement or could easily fall through the cracks. They compound the issue of poverty often suffering from the same health outcomes and poor health behaviors as those considered impoverished.



Many Washington County households are economically strained with 30% or more of their gross income going to basic housing costs, leaving little for other costs, especially those related to preventive health care and higher cost nutritionally sound foods.



Many of the Towns in the County have greater than 40% of households defined as under resourced.

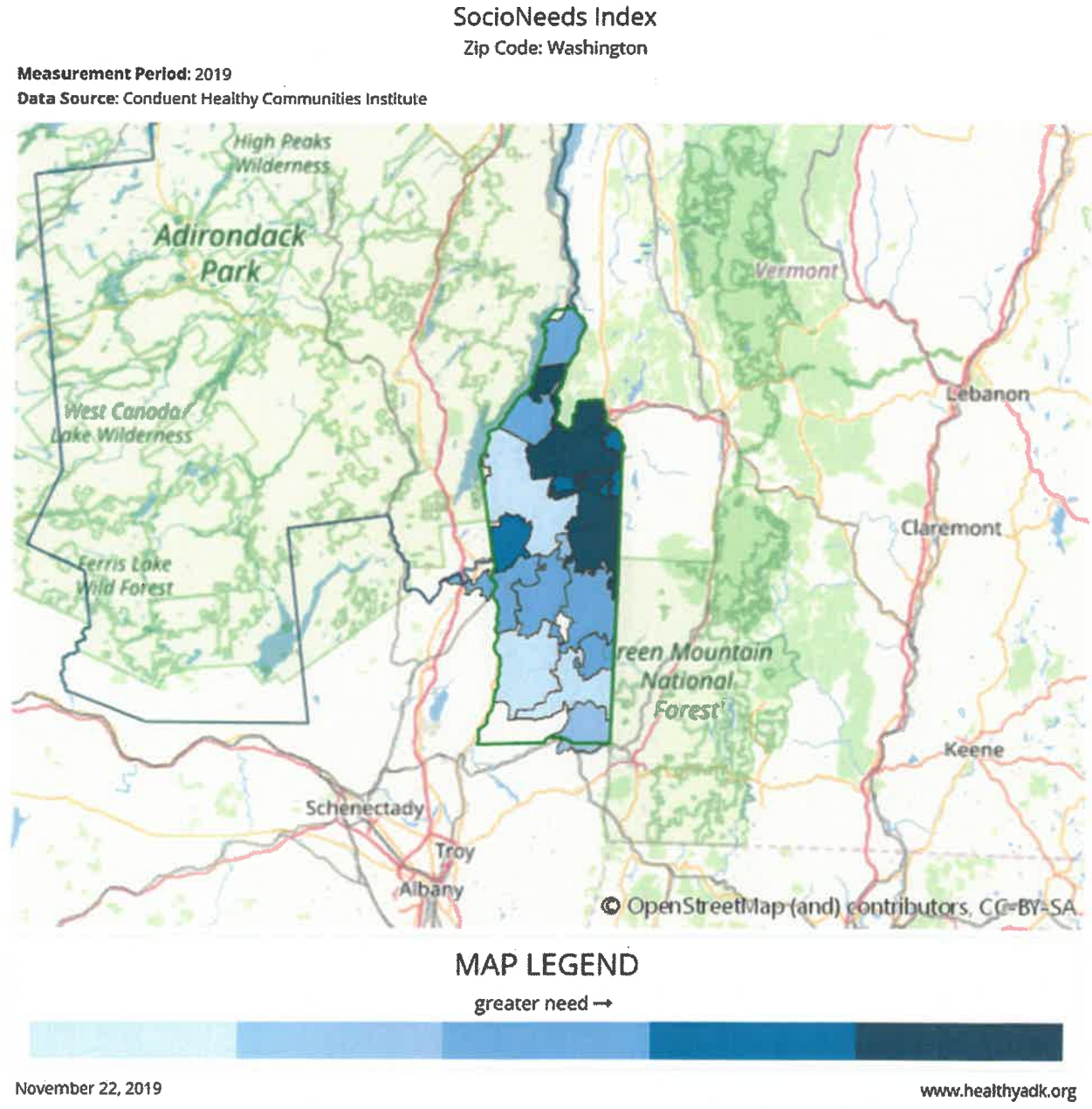


Washington County women head of household are disproportionately impoverished.

Socio-Needs Index

The **2019 Socio-Needs Index**, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes.

All zip codes, counties, and county equivalents in the United States are given an **Index Value** from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are **ranked** from 1 (low need) to 5 (high need) based on their Index Value



Social Determinants of Health

Social determinants of health are the social and environmental factors that influence individual and population health outcomes. Shaped by policy and the resulting distribution of resources, the circumstances in which people are born, grow, live, work and age account for most factors impacting a person's health and wellness. Some of the more frequently cited unmet social needs in the Adirondack region include reduced access to health care, food insecurity, lack of reliable transportation, lack of safe and affordable housing, low income, and limited employment opportunities.

A 2017 survey conducted by the American Academy of Family Physicians found that 83% of family physicians agree they should help with identifying and addressing social factors that influence patients' health outcomes, but 56% felt unable to provide solutions to patients to resolve unmet social needs.

This study indicates an ongoing need for greater education and guidance to support health care providers' efforts in this arena.

Our region is in the initial phases of implementing and standardizing processes to screen for social determinants of health and develop referral pathways between clinical providers and community-based organizations to address identified needs. This will enable health care providers to incorporate this information and resulting processes into clinical practice, outcomes measurement, and payment models. Below are recommended steps, informed by lessons learned through our regional initiatives along with recognized best practices, to guide providers in taking steps to address the role social needs play in their patients' and clients' health and wellness:

•Identify unmet social needs through screening. Select a screening tool that's most appropriate for your patient population and that will collect information meaningful to the individual and the practice.

•Leverage patient-centered, culturally-competent patient engagement strategies, such as motivational interviewing, to understand the root cause of the identified need and build rapport with the patient.

•Manage expectations around the ability to address needs. Have a plan in place for responding to urgent needs and those that present an imminent safety risk to the patient or others.

•Refer patients to community-based service providers with the capacity to address identified needs.

•Whenever possible, have standardized care pathways in place for addressing commonly-identified needs, such as through an established partnership with a community service provider. For example, if access to healthy foods impacts many patients in your practice, consider opportunities for collaboration with food providers to create food prescription programs.

•Have a standardized referral and linkage process that includes monitoring and tracking referral outcomes (closed-loop referrals).

•Collect and analyze data from screening and referral processes to better understand needs specific to your patient population, as well as to contribute to a larger picture of population health in your region. Data can be used at the practice level to inform development of CBO partnerships and selection of interventions to implement. At the regional level, data collected can be used to advocate for policy change or support requests for funding.

Health Disparities:

While there are no significant health disparities based on race and ethnicity in Washington County, there are significant access to care issues. The percentage of adults with health insurance in Washington County is at 93.5%, with 94.2% of the population having a regular health care provider. The rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older (153.2) is higher than the rate for Upstate New York (116.8), and the Prevention Agenda benchmark (122.0) rate. The rate of ED visits per 10,000 population in Washington County (3,541.1) is lower than the ARHN region (4,866.3) and Upstate New York (3,865.6). Lastly, the percentage of adults 18 years of age and older in Washington County with disability (24.0%) is lower than the ARHN region (25.6%), but higher than Upstate New York (22.8%), and the state (22.9%).

Inequities in external conditions referred to as social determinants of health lead to health disparities. Health disparities are measurable differences in health outcomes linked to populations living with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who've encountered systemic barriers to health due to characteristics historically linked to discrimination or exclusion. These can include race, ethnicity, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, and geographic location among others.

While health disparities in the Adirondack region reflect some similarity to those experienced by groups across New York State, demographic differences must be considered to sufficiently address regional issues. Relative to Upstate New York and New York State as a whole, the Adirondack region is characterized by lower educational attainment, higher unemployment rates, an aging population, higher disability rates, lower household incomes, higher poverty rates, and a vastly rural composition.

Each of these attributes can increase the incidence of significant health disparities. Mental health and substance abuse are significant issues, affecting at least one-third of the Medicaid population, and driving significant emergency department utilization across the region. Poverty in the Adirondacks is exceptionally severe. Of those in poverty, there are greater proportions at or below 138% of the Federal Poverty Line (FPL) and 200% FPL compared to Upstate New York.

Data, such as that collected through Community Health Assessments, can help identify health disparities and inform targeted interventions to address them. General guidelines for decreasing regional health disparities include:

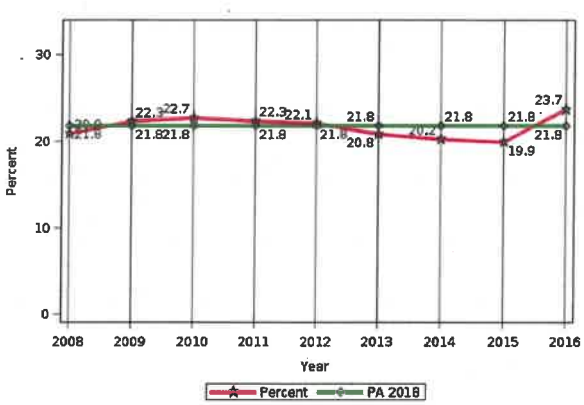
- Increasing capacity and reach of primary care and preventative services.
- Strengthening integration and information-sharing infrastructure across the continuum of care.
- Leveraging community-based interventions and resources to address patients' unmet social needs.
- Gathering stakeholder input to inform quality improvement initiatives.
- Implementing culturally competent and health literate health care practices.

The primary disparity noted in Washington County is Poverty and Asset Limited Income Constrained Employed individuals and families. Poverty increases the risk of mental health issues and can be both a causal factor and a consequence of mental ill health. An Individuals mental health is shaped by a wide range of characteristics of their social, economic and physical environment including the inherent inequities. In addition, poverty is also correlated with a

higher prevalence of cigarette smoking. According to BRFSS data 45.5% of Washington County residents with annual household incomes less than $25,000 are current smokers. There is also a higher percent of females living below poverty in the County compared to males. The percent of female smokers (27.3%) exceeds the male smokers (14.9%) in the County.

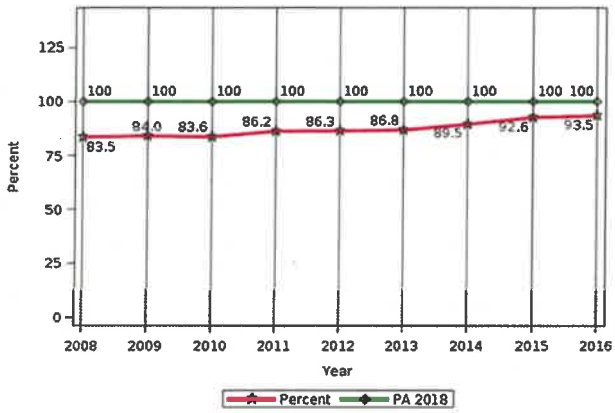
Years of Potential Life Lost (YPLL) is a measure of the rate of premature mortality. The intent of the measure is to focus on deaths that could have been prevented. The measure highlights the deaths of younger persons. The average age of death in the United States is 75 years. Oftentimes early death can be attributed to negative health behaviors such as smoking, poor diet, and physical inactivity.

Washington County - Percentage of premature deaths (before age 65 years)



It is interesting to note that 93.5% of residents have health insurance of some type, but only 24.2% have a regular health care provider. Residents have the coverage for medical care, but do not routinely engage a health care provider. High deductible plans and co-pays can prevent those with limited expendable income from seeking routine check ups and preventive care and screenings. Late stage diagnosis of diseases /cancers and low utilization of preventive screenings is indicative of low utilization of non-sick care visits to primary care.

Washington County - Percentage of adults (aged 18-64) with health insurance



Injuries, Violence, and Occupational Health:

Motor vehicle accidents and speed-related accidents are lower in Washington County (1,695.9 and 266.2 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is lower in Washington County (4.9) than the ARHN region (7.3), Upstate New York (7.1) and the state (5.0). The rate of violent crimes (124.8) is significantly lower than the ARHN region (171.8), Upstate New York (214.9) and New York State (355.6).

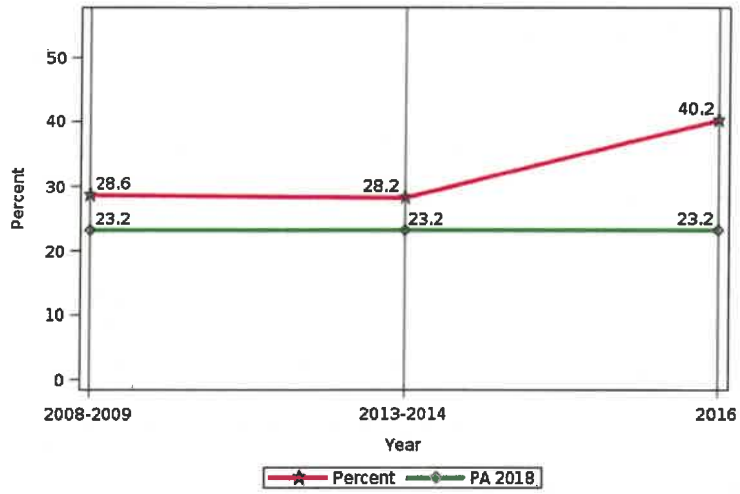
Outdoor Air and Water Quality and Built Environment:

The built environment poses several challenges in Washington County. The percentage of the population with low-income and low access to supermarkets or large grocery stores is lower in Washington County (4.4%) than in the ARHN region (6.0%), but higher than Upstate New York (3.9%), New York State (2.3%) and the Prevention Agenda Benchmark of 2.2%. Rural living and lack of transportation to shopping areas can limit access.

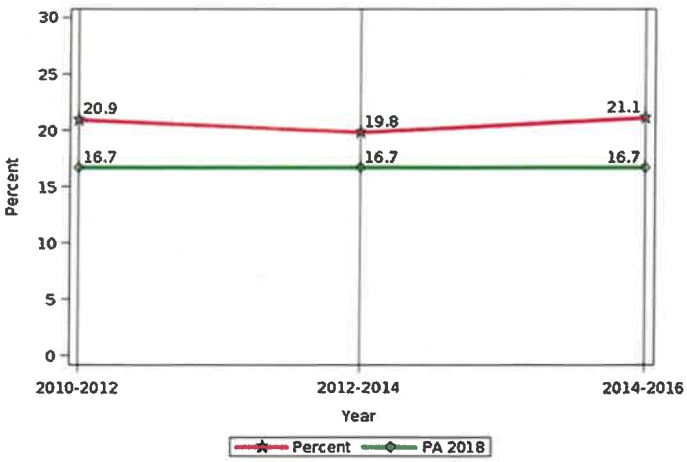
Obesity in Children and Adults:

The percentages of adults (40.2%) and children who are obese (21.1%) in Washington County are higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the rate of obesity in elementary school children (18.4%) is higher than Upstate New York (16.0%). The burden of obesity may contribute to higher rates of death and hospitalization due to diabetes (any diagnosis) in Washington County (32.7 and 265.4 respectively) than in Upstate New York (15.4 and 237.2).

Washington County - Percentage of adults who are obese



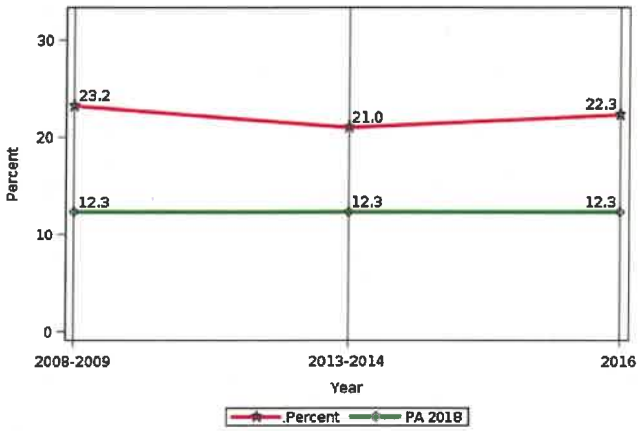
Washington County - Percentage of children and adolescents who are obese



Chronic Disease:

Smoking and smoking-related diseases pose a significant challenge for Washington County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Washington County (22.3%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. Chronic lower respiratory deaths and hospitalizations are higher in Washington County (78.3 and 40.3, respectively) than in Upstate New York (45.4 and 28.0) and the state (34.1 and 30.6). The percentage of adults with asthma in Washington County (9.3%) is slightly lower, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%).

Washington County - Percentage of cigarette smoking among adults



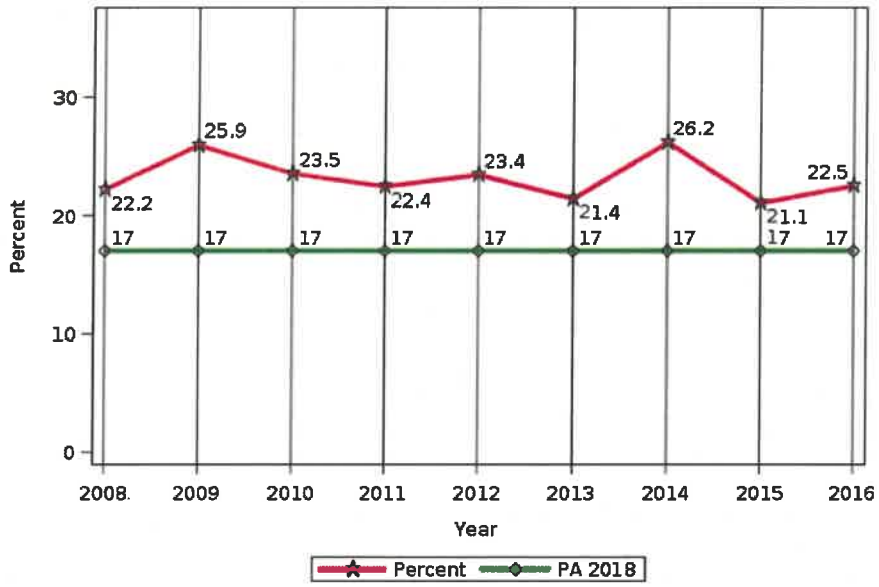
The rates of lung and bronchus cancer cases are lower in Washington County (102.4) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths in Washington County (67.2) are comparable to the ARHN region (67.4), and higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Washington County (56.5 and 18.7) is comparable to those of the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Washington County (69.0%) is lower than the ARHN region (73.6%), and in line with Upstate New York (68.5%), and New York State (69.7%).

Women, Infants and Children:

The percentage of births within 24 months of previous pregnancies in Washington County (22.5%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Washington County (39.1%), with the Prevention Agenda Benchmark being 23.8%.

The percentage of women receiving WIC in Washington County with either gestational weight gain greater than ideal is worse than the ARHN region. The percentage of pre-pregnancy obesity (31.7%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%). Closely spaced pregnancies can be detrimental to the health of mother and baby and can lead to long term health issues. Unintended or unrecognized pregnancies can lead to late or no prenatal care, poor or no preconception health planning and health and behavior changes related to smoking, diet, substance use and nutritional concerns.

Washington County - Percentage of live births that occur within 24 months of a previous pregnancy



HIV/STD's, Vaccines-Preventable Disease, and Health Care-Associated Infections:

The immunization rate for children ages 19 – 35 months with 4:3:1:3:3:1:4 (76.2%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (42.9%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Washington County (1.1*) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older is lower in Washington County (82.9) than in ARHN region (93.3), Upstate New York (93.7), and the state as a whole (87.3).

Substance Abuse and Behavioral Health:

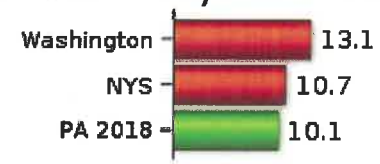
The percentage of adults in Washington County who binge drink (21.7%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (13.1%) is higher than the Prevention Agenda

Benchmarks of 10.1%. This metric is of concern as is BRFSS data and self-reported. Actual rates are assumed to be greater than reported. The rate of self-inflicted hospitalizations in Washington County (7.6) is higher than in Upstate New York (4.1). The rate of alcohol-related crashes in Washington County (71.4) is significantly higher than New York State (38.0).

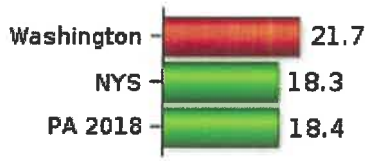
Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 9.2*, which is lower than the ARHN region (10.7) and higher than Upstate New York (6.1).

Substance use disorders and mental health disorders such as depression and anxiety are closely linked, while some substance use can cause mental health (psychotic) issues they are not lined causatively. Alcohol and drugs are often used to self-medicate the symptoms of mental health problems. Moreover, poverty can be linked to depressive and anxiety disorders, psychological stress and suicide. Poverty affects mental health through an array of social and ecological mechanisms acting at multiple levels on the individual, family and communities.

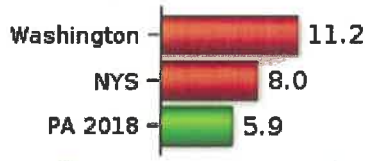
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month



Age-adjusted percentage of adults binge drinking during the past month



Age-adjusted suicide death rate per 100,000 population



https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch&cos=53

Other Findings:

The salmonella case rate is similar in Washington County (12.3) as in the ARHN region (12.0), Upstate New York (12.0), and New York State (11.6). However, the rate of confirmed rabies is much higher in Washington County (6.4) than in Upstate New York (3.3). As noted, Washington County is a largely rural, farm community. Opportunity for exposure to salmonella from various sources and exposure to rabies vector species is high due to the environments in which people live, work and play.

Community Input

Stakeholder Survey

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

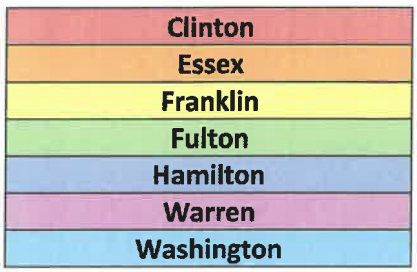
An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties. All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.



Summary Analysis

1. Indicate county/counties served

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

*Figures do not add up to 100% due to multiple counties per organization.

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (19.0%), Health Care (13.2%), Social Services (12.5%), Public Health (9.2%), and Health Based Community Based Organizations (CBO) (7.5%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53
Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

3. Indicate your job title

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	Responses	
	Count	Percentage
Community Member	5	1.25%
Direct Service Staff	94	23.44%
Program/Project Manager	40	9.98%
Administrator/Director	171	42.64%
Other	91	22.69%

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

NYS Prevention Agenda Top Priority Area for the ARHN Region		
County	First Choice	Second Choice
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice.*

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Essex, Franklin and Fulton counties identified *Prevent Chronic Disease* as their second choice while Clinton, Essex, Warren and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice. Clinton and Essex counties have an overlap due to ties.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

NYS Prevention Agenda Top Priority Area by County		
County	**First Choice**	**Second Choice**
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

*Overlapping in county choices is due to several ties in response totals.

5. In your opinion, what are the top five health concerns affecting the residents of the counties your organization/agency serves?

Health Concerns for the ARHN Region:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (16.9%), Substance Abuse (12.3%), Opioid Use (9.5%), Overweight/Obesity (8.8%),* and *Child/Adolescent Emotional Health (5.7%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8
Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5

Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5

Health Concerns by County:

Overall, most of the health concerns identified per county aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Three out of the seven ARHN counties listed *Adverse Childhood Experiences* as a top health concern in their county.

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

Top Five Health Concerns by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Mental Health Conditions	Overweight/Obesity	Opioid Use	Senior Health	Heart Disease
Essex	Substance Abuse	Mental Health Conditions	Child/Adolescent Emotional Health	Overweight/Obesity	Adverse Childhood Experiences
Franklin	Mental Health Conditions	Overweight/Obesity	Substance Abuse	Opioid Use	Adverse Childhood Experiences
Fulton	Mental Health Conditions	Substance Abuse	Tobacco Use	Opioid Use	Child/Adolescent Emotional Health
Hamilton	Substance Abuse	Mental Health Conditions	Overweight/Obesity	Heart Disease	Diabetes
Warren	Mental Health Conditions	Overweight/Obesity	Adverse Childhood Experiences	Substance Abuse	Alzheimer's Disease
Washington	Substance Abuse	Mental Health Conditions	Opioid Use	Alzheimer's Disease	Cancers

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

Respondents were asked to identify what they believed to be the top five contributing factors to the health concerns they chose. The contributing factors were ranked from one to five, with one being the highest contributing factor and five being the lowest.

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
ARHN Region Contributing Factors	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Addiction to alcohol	14	16	12	7	6
Addiction to illicit drugs	37	36	22	13	5
Addiction to nicotine	7	10	6	7	11
Age of residents	28	11	6	4	7
Changing family structures (increased foster care, grandparents as parents, etc.)	36	22	15	20	8
Crime/violence/community blight	0	1	2	1	4
Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	0	1	0	3
Discrimination/racism	0	0	0	0	1
Domestic violence and abuse	4	6	5	4	7
Environmental quality	0	3	4	5	6
Excessive screen time	2	13	11	4	8
Exposure to tobacco smoke/emissions from electronic vapor products	1	3	5	1	3
Food insecurity	8	13	9	8	7
Health care costs	16	17	21	20	16
Homelessness	1	2	4	4	2
Inadequate physical activity	5	16	15	17	21
Inadequate sleep	0	0	2	3	3
Inadequate/unaffordable housing options	5	9	16	8	13
Lack of chronic disease screening, treatment and self-management services	3	8	7	7	4
Lack of cultural and enrichment programs	1	2	1	1	3
Lack of dental/oral health care services	1	3	0	6	7
Lack of educational opportunities for people of all ages	1	2	3	2	9
Lack of educational, vocational or job-training options for adults	1	1	0	6	1
Lack of employment options	1	3	12	7	7
Lack of health education programs	3	1	4	3	2
Lack of health insurance	3	1	4	3	3
Lack of intergenerational connections within communities	1	0	2	4	8
Lack of mental health services	35	28	27	26	9
Lack of opportunities for health for people with physical limitations or disabilities	2	0	1	4	4
Lack of preventive/primary health care services (screenings, annual check-ups)	6	5	2	3	3
Lack of social supports for community residents	4	3	10	8	9
Lack of specialty care and treatment	1	4	4	3	2

Lack of substance use disorder services	8	8	11	4	6
Late or no prenatal care	0	0	1	2	3
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	0	1
Poor access to healthy food and beverage options	5	2	6	9	0
Poor access to public places for physical activity and recreation	2	3	1	3	4
Poor educational attainment	2	8	2	8	8
Poor community engagement and connectivity	6	5	4	6	14
Poor eating/dietary practices	12	15	15	17	12
Poor health literacy (ability to comprehend health information)	6	2	4	5	4
Poor referrals to health care, specialty care, & community-based support services	8	5	4	4	7
Poverty	43	18	16	16	23
Problems with Internet access (absent, unreliable, unaffordable)	0	0	0	3	2
Quality of schools	0	0	1	1	3
Religious or spiritual values	0	0	0	1	1
Shortage of child care options	0	1	3	1	3
Stress (work, family, school, etc.)	7	10	15	21	9
Transportation problems (unreliable, unaffordable)	9	13	15	13	14
Unemployment/low wages	3	6	3	8	13

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Franklin, Hamilton and Warren counties was *Health Care Costs*.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Food Insecurity	Addiction to Illicit Drugs	Lack of Mental Health Services	Inadequate Physical Activity
Essex	Poverty	Lack of Mental Health Services	Changing Family Structures	Addiction to Illicit Drugs	Age of Residents
Franklin	Poverty	Lack of Mental Health Services	Addiction to Illicit Drugs	Changing Family Structures	Health Care Costs
Fulton	Lack of Mental Health Services	Poverty	Poor Eating/ Dietary Practices	Changing Family Structures	Addiction to Illicit Drugs
Hamilton	Age of Residents	Health Care Costs	Lack of Mental Health Services	Poverty	Poor Community Engagement and Connectivity
Warren	Age of Residents	Lack of Mental Health Services	Changing Family Structures	Health Care Costs	Poverty
Washington	Addiction to Illicit Drugs	Age of Residents	Poverty	Lack of Mental Health Services	Changing Family Structures

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "excellent" to (5) "very poor".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, excellent, to five, very poor. The table below encompasses response counts for the entire survey.

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Excellent)**	**2**	**3**	**4**	**5 (Very Poor)**
Economic Stability (consider poverty, employment, food security, housing stability)	54	22	33	53	100
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	50	67	66	49	27
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	70	64	79	52	49
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	35	67	61	79	43
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	32	58	73	62	38

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	0	5	1	1	2	5	4
Females of reproductive age	0	0	0	0	0	0	0
Individuals living at or near the federal poverty level	35	46	32	14	19	25	39
Individuals living in rural areas	5	6	7	2	8	12	17
Individuals with disability	1	2	0	0	0	1	0
Individuals with mental health issues	19	24	19	11	9	14	29
Individuals with substance abuse issues	2	8	4	1	6	7	16
Migrant workers	1	1	1	0	0	0	0
Seniors/Elderly	5	7	6	6	10	8	17
Specific racial or ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	1	0	1	1	1	2
Total per county	**68**	**101**	**70**	**37**	**56**	**74**	**126**

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation*. Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Essex	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Franklin	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Promote the use of evidence-based care to manage chronic diseases
Fulton	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Increase skills and knowledge to support healthy food and beverage choices
Hamilton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Warren	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Washington	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Franklin	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	Increase supports for children with special health care needs
Hamilton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health

			equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce falls among vulnerable populations
Essex	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Franklin	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Hamilton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Warren	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles,

			sustainability, and adaptation to climate change

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *Facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Five counties also listed *Prevent opioid and other substance misuse and deaths* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Prevent opioid and other substance misuse and deaths	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates, improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Essex	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Reduce inappropriate antibiotic use	Improve vaccination rates	Improve infection control in health care facilities
Warren	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

12. Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	208	70.99%
Share knowledge of community resources	204	69.62%
Deliver education and counseling relevant to the selected goal(s)	189	64.51%
Provide subject-matter knowledge and expertise	182	62.12%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	164	55.97%
Facilitate access to populations your organization/agency serves	139	47.44%
Provide letters of support for planned health improvement activities	124	42.32%
Offer health related-educational materials	117	39.93%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	112	38.23%
Work to promote changes to policies/laws/community environment to address selected goal(s)	111	37.88%

Community Stakeholder Summary:

Top five contributing factors to poor health

- Poverty
- Addiction
- Changing family structure
- Lack of mental health services
- Aging population.

Top four stakeholder concerns:

- Substance Use
- Mental health conditions
- Alzheimer's Disease
- Cancers

Populations experiencing the poorest outcomes:

- Those in poverty
- Those experiencing mental health issues
- Those in rural areas
- The Elderly
- Those with Substance Use Disorders

II. Washington County Community Health Assessment Resident Survey (Appendix I)

Survey Methodology:

Survey creation: The 2019 Washington County Community Health Assessment Resident Survey was drafted by public health administration based on historical identified data needs and the desire to include the general public in the priority setting process. Surveys from other regional health departments and nationally sourced community surveys were reviewed and assessed for useful knowledge, question validity, specificity and effectiveness.

Survey facilitation: Washington County Public Health staff deployed the surveys by two survey modalities, paper in person and online via Survey Monkey. The goal was to glean community input and information regarding health care needs and identified community level priorities. Stakeholders included young adults and adult residents of the towns and villages in Washington County.

Survey logistics: Survey modalities included in person paper surveys distributed at the Washington County Fair, the larges attended social event of the year in the County. It draws a large cross section of the population. The second modality was through Survey Monkey, participation was encouraged through wide spread advertisement on County social media sites, via distribution to other community based and county organizations that serve the public to engage their constituents and via clinics and home visits conducted by public health staff.

Survey Response and Analysis:

Limitations:

- ✓ Not everyone answered every question
- ✓ Some gave more than the requested number of responses, some less. All were counted
- ✓ Responses are limited to those who took the time to respond and have the means to.
- ✓ Sampling is not all inclusive, some holes
- ✓ Geographic differences
- ✓ Age /sex responses are not equal and subject to bias
- ✓ Does not include the hard to reach
- ✓ Accuracy of answers
- ✓ Comfort with unfavorable or unexpected responses
- ✓ Non-response, choosing some questions to answer over others
- ✓ Individual interpretation of what is being asked or the meaning of questions related to interviewer intent and responder understanding
- ✓ Point in time survey may reflect current events, recent experiences good or bad. This influences answers versus overtime experience.
- ✓ Over simplification of social reality simply by design

Advantages:

Inexpensive	Easy analysis
Practical	Validity and reliability
Fast results	Standardized
Scalable	No pressure
comparable	Respondent anonymity

Disadvantages:

Dishonest answers	Hidden agenda -respondent bias
Skipped questions	Lack of personalization
Interpretation issues	Unconscientious responses -understanding
Lack of nuance (feeling, emotion)	Accessibility issues
Analysis issues	Survey fatigue

1. **Biggest Health Issues:**

2. Overweight/obesity
3. Cancer
4. Substance abuse
5. Tobacco /vaping

Lowest scores:

1. Prenatal care/ Maternal Child Health
2. Infectious Disease
   STD
3. Falls

1. **Social Issues of greatest concern:**
   1. Bullying
   2. Unemployment/low pay
   3. Transportation

   Lowest scores:

   1. Elder abuse/ neglect
   2. Crime/incarceration rates
   3. Racism/discrimination

3. **Environmental Issues:**

   1. Mosquitos /ticks
   2. Drinking water quality
   3. Exposure to tobacco smoke

   Lowest scores:

   1. Safe food
   2. Lead paint hazards
   3. Home safety
      Agricultural run- off

4. **Features of a strong and vibrant, healthy community:**

   1. Good schools
   2. Safe environments
   3. Good Pay
      Good healthcare services

   Lowest scores:

   1. Diverse populations

2. Wide range of Senior services
3. Available childcare
   Healthy food choices

5. **Barriers that keep people from getting the healthcare they need-what you do feel they are?**

1. Could not pay
2. Do not have health insurance
3. Do not have transportation

Lowest scores:

1. Provider did not speak my language
2. None of the above
3. No access for those with disability
4. No appointments available

Brief Respondent profile:

Female -83%

45-64 y.o. -36%

Characterize themselves as healthy almost 2:1 over somewhat healthy (51%:29%)

Benefits received:

1. None
2. SNAP
3. HEAP

Most had a high school diploma or GED- 31%

Some college or trade school -22%

Bachelor's degree- 20%

A vast majority had a healthcare provider that they see for routine needs 140(95%) only 8(4%) did not.

86% characterized their community as somewhat health or healthy

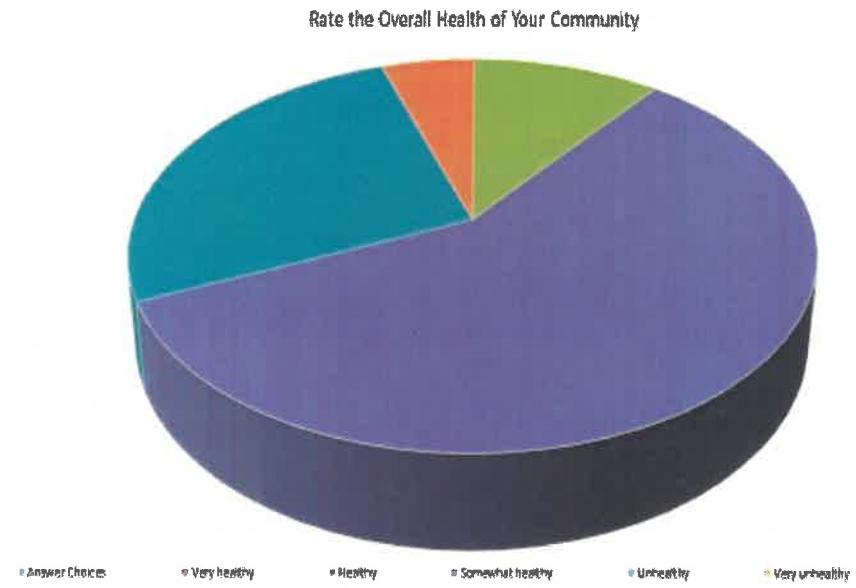
68% characterized themselves as healthy or very healthy

4% characterized their community as unhealthy

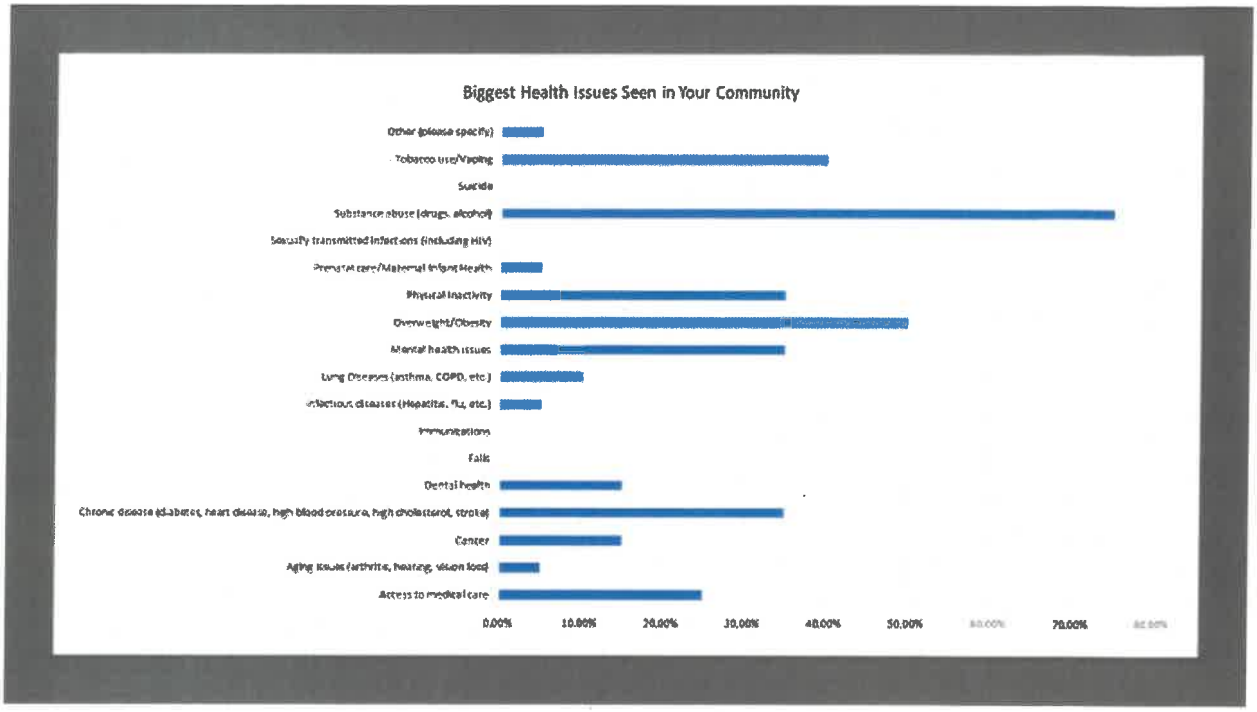
4% characterized themselves as unhealthy

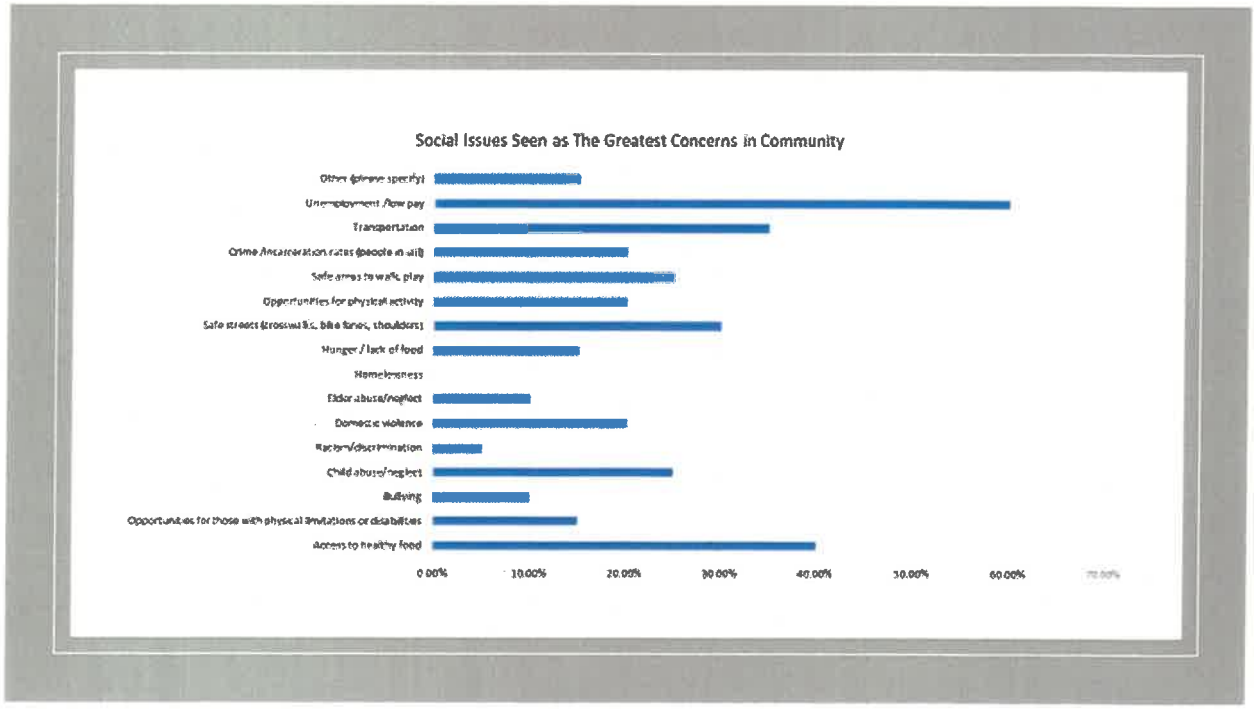
See Appendix I for qualitative responses.

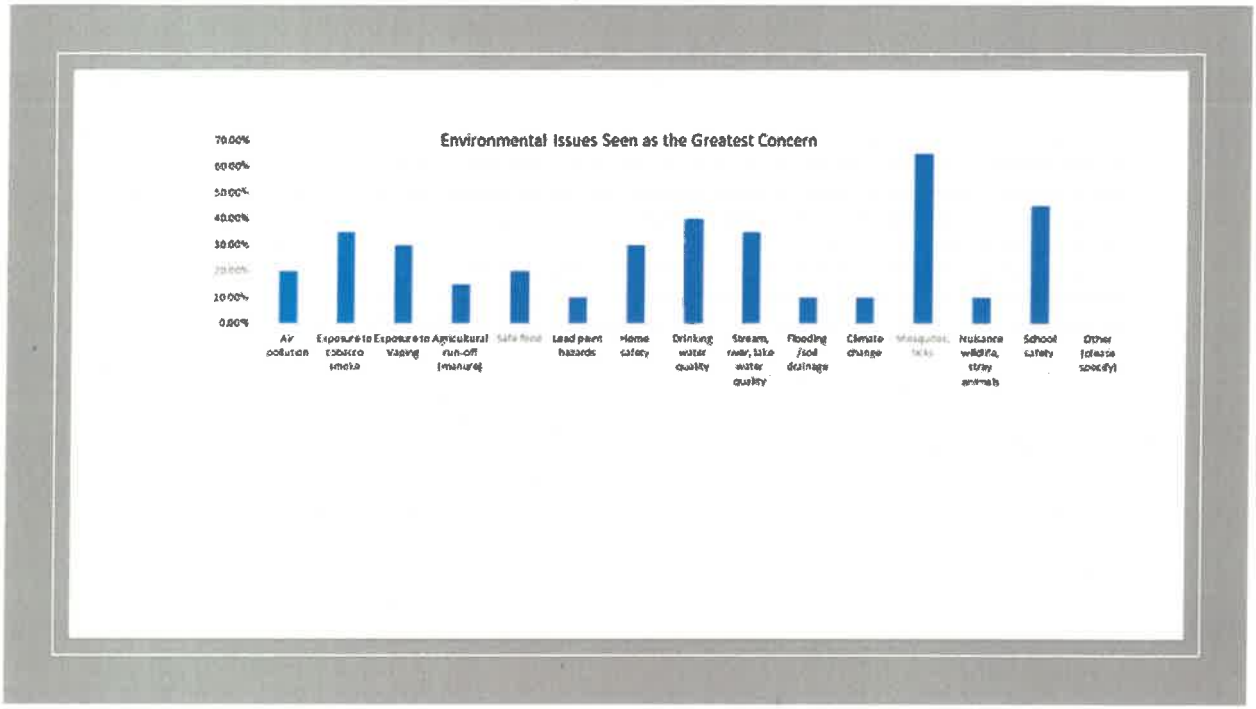
2019 Washington County Resident Community Health Survey N=224

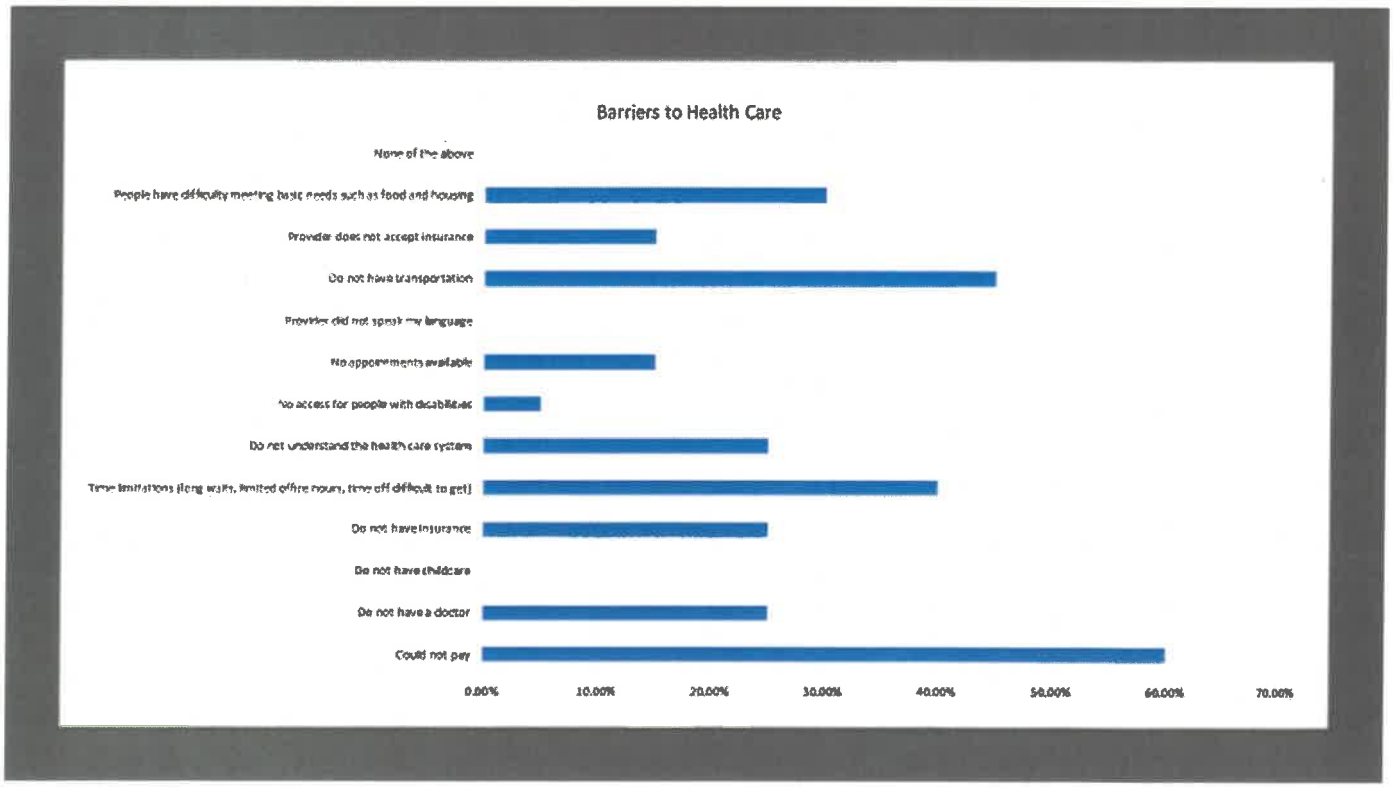


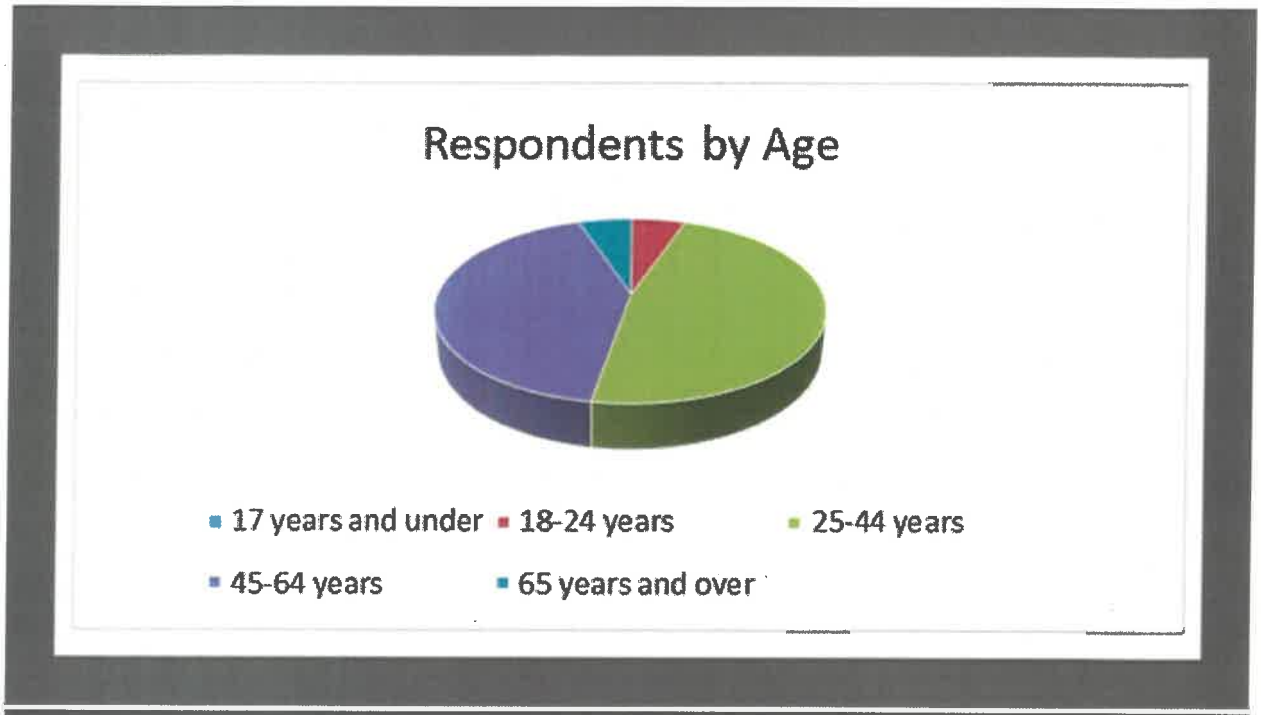
224 County residents ages 17-65+years answered the resident survey. Respondents were predominately female, insured and reported having a routine primary care provider.

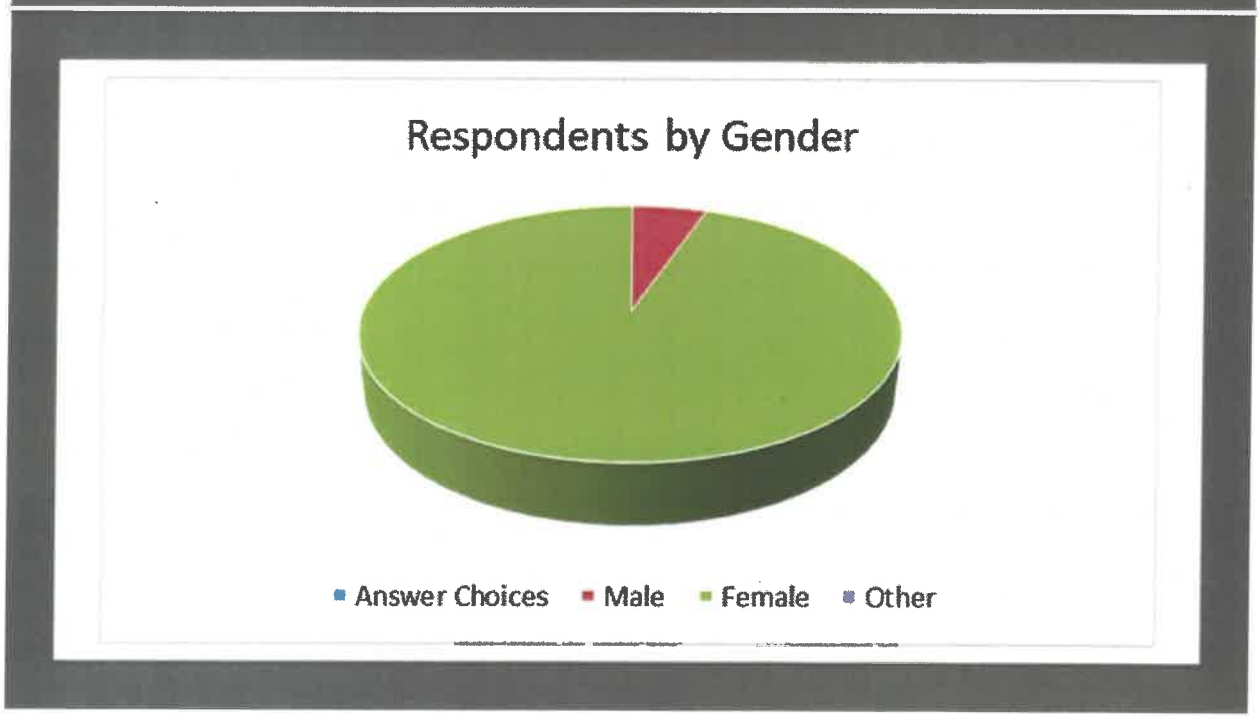

Biggest Health Issues Seen in Your Community
Other (please specify)
Tobacco use/Vaping
Suicide
Substance abuse (drugs, alcohol)
Sexually transmitted infections (including HIV)
Prenatal care/Maternal Infant Health
Physical inactivity
Overweight/Obesity
Mental health issues
Lung Diseases (asthma, COPD, etc.)
Infectious diseases (Hepatitis, Flu, etc.)
Immunizations
Falls
Dental health
Chronic diseases (diabetes, heart disease, high blood pressure, high cholesterol, stroke)
Cancer
Aging issues (arthritis, hearing, vision loss)
Access to medical care
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
70.00%

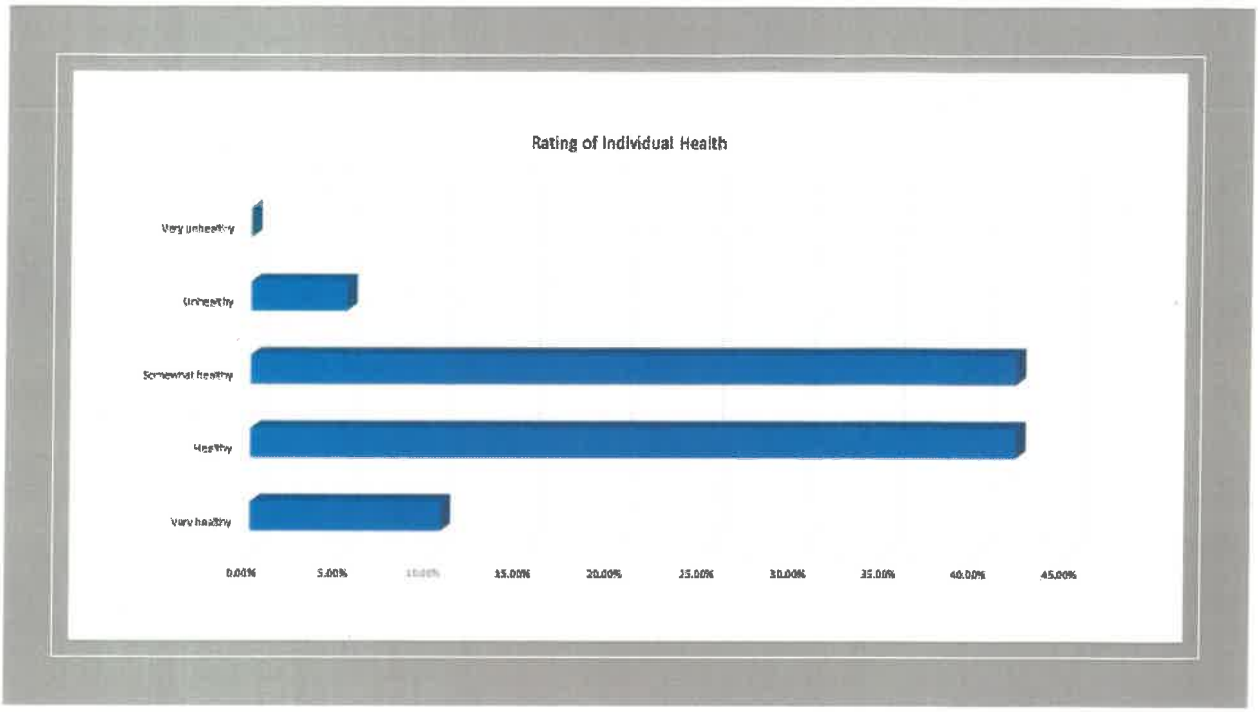

Social Issues Seen as The Greatest Concerns in Community
Other (please specify)
Unemployment /low pay
Transportation
Crime /incarceration rates (people in jail)
Safe areas to walk, play
Opportunities for physical activity
Safe streets (crosswalks, bike lanes, shoulders)
Hunger / lack of food
Homelessness
Elder abuse/neglect
Domestic violence
Racism/discrimination
Child abuse/neglect
Bullying
Opportunities for those with physical limitations or disabilities
Access to healthy food
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%

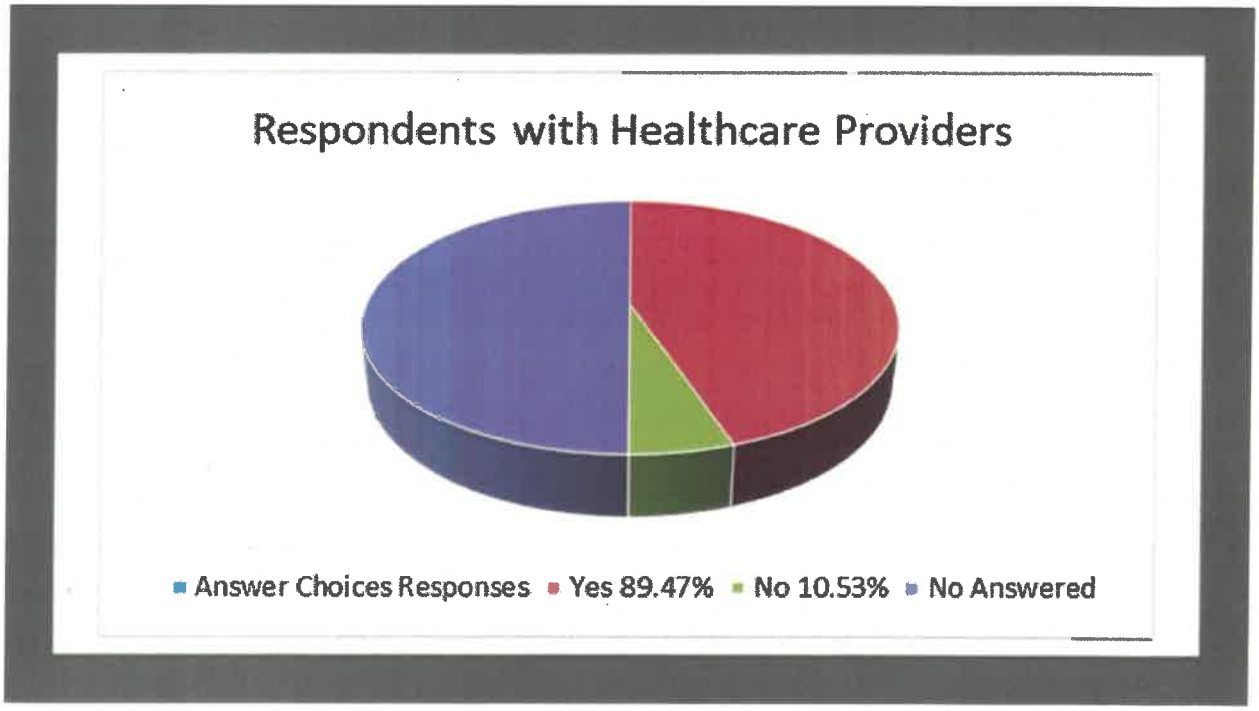

Environmental Issues Seen as the Greatest Concern
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Air pollution
Exposure to tobacco smoke
Exposure to vaping
Agricultural run-off (manure)
Lead paint hazards
Home safety
Drinking water quality
Stream, river, lake water quality
Flooding /soil drainage
Climate change
Nuisance wildlife, stray animals
School safety
Other (please specify)

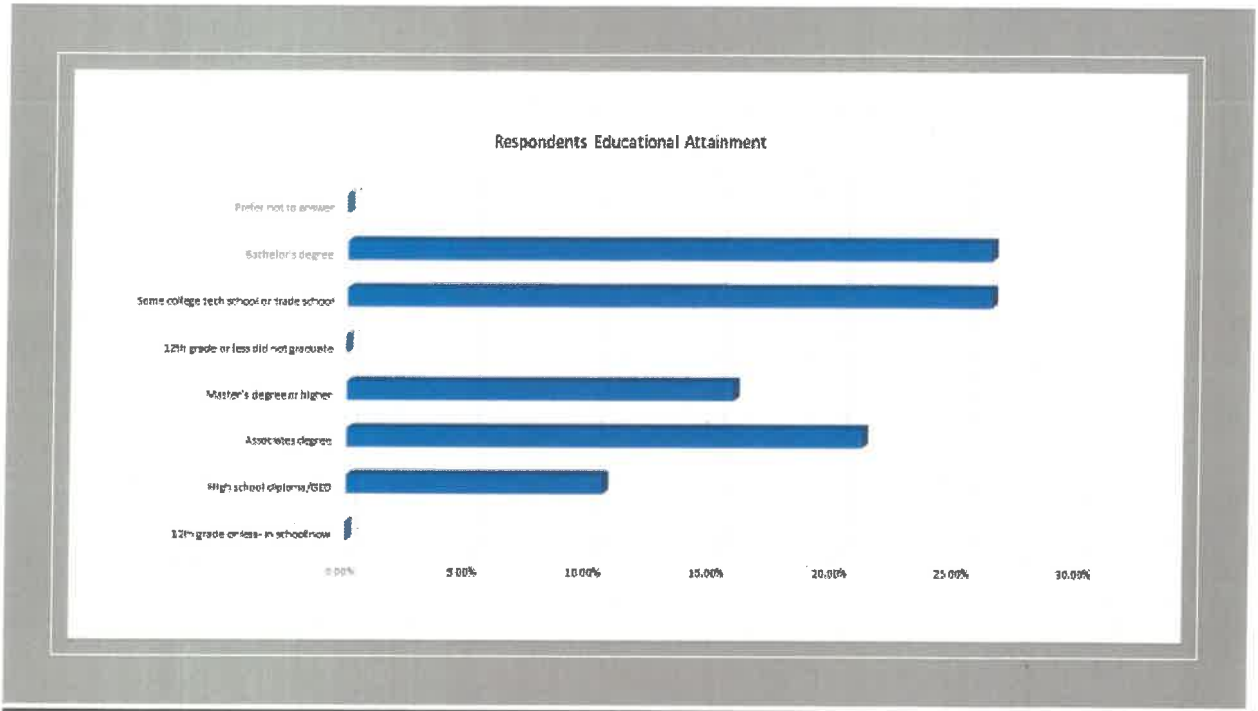

Barriers to Health Care
None of the above
People have difficulty meeting basic needs such as food and housing
Provider does not accept insurance
Do not have transportation
Provider did not speak my language
No appointments available
No access for people with disabilities
Do not understand the health care system
Time limitations (long waits, limited office hours, time off difficult to get)
Do not have insurance
Do not have childcare
Do not have a doctor
Could not pay
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%

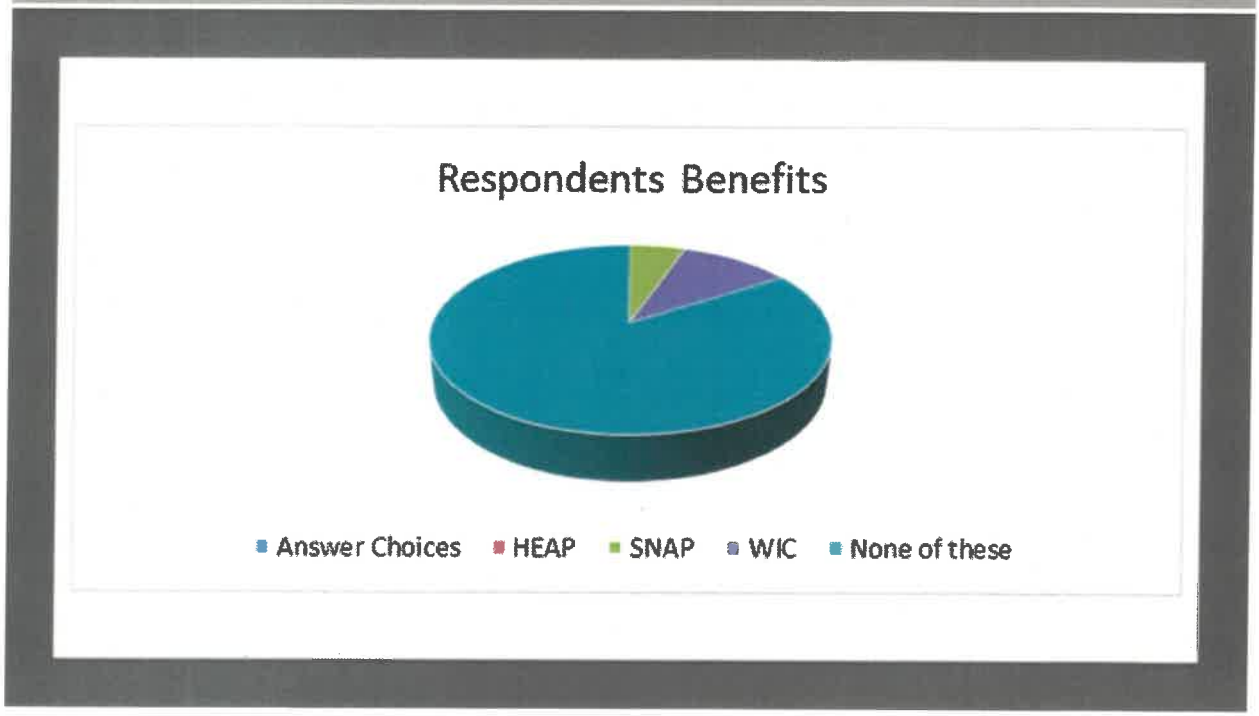

Respondents by Age
17 years and under
18-24 years
25-44 years
45-64 years
65 years and over


Respondents by Gender
Answer Choices
Male
Female
Other


Rating of Individual Health
Very unhealthy
Unhealthy
Somewhat healthy
Healthy
Very healthy
0.00%
5.00%
15.00%
20.00%
25.00%
30.00%
35.00%
40.00%
45.00%


Respondents with Healthcare Providers
Answer Choices Responses
Yes 89.47%
No 10.53%
No Answered


Respondents Educational Attainment
Prefer not to answer
Bachelor's degree
Some college tech school or trade school
12th grade or less did not graduate
Master's degree or higher
Associates degree
High school diploma/GED
12th grade or less- in school now
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%


Respondents Benefits
Answer Choices
HEAP
SNAP
WIC
None of these

Drivers of Poor Health

- Poverty
- Aging population
- Built environment
- Housing insecurity
- Food insecurity
- Transportation challenges
- Insurance copays, high deductibles.
- Rurality
- Access to care
- Lack preventive care/screening.
- Obesity
- Smoking
- Hypertension
- Diabetes
- Chronic lung and respiratory diseases
- Disability
- Teen pregnancy , lack early prenatal care and closely spaced pregnancies.
- STI
- Mental health

Rurality

- Anonymity, trust, confidence
- Lack of providers, services, outreach
- Distance/weather
- Lack transport, personal, public
- Inequitable reimbursement, policies
- Lack of know how
- Care/services "culturally" appropriate
- Self reliance, independence, strength
- Technology challenges
- Working poor more prevalent (ALICE)

2019 Washington County Resident Survey Categorical Qualitative Responses N=224

- Seniors/Aging
- Access
- Lyme, Ticks, Environment (water)
- Social issues (Social determinants of health)
- Transportation
- Need for Education /information

Summary

Improve health status/disparities, social determinants of health, ALICE.

Chronic Disease: obesity, tobacco use, Smoking, Chronic disease preventive care & management.

Mental Health, Behavioral Health and Substance Use Disorders.

Priority Selection

See Appendix J for AHI prioritization sheet and data analysis/methodology

Selection Basis and Method

Washington County Public Health worked with several partners, through the Washington County Healthy Communities Coalition to review data and determine if the health priorities in Washington County had changed since the last CHA was submitted in 2013. Partners include Glens Falls Hospital, Glens Falls Hospital Health Promotion Center programs such as Creating Healthy Places to Live Work and Play, Healthy Schools New York, and the Tobacco Cessation Center. Other partners include Glens Falls Hospital CR Wood Cancer Center, Washington County Office for the Aging ADRC, Washington County WIC, Cornell Cooperative Extension, Washington County Youth Bureau/Alternative Sentencing, Planned Parenthood, Adirondack Health Institute and the AHI Population Health Improvement Program and Warren Washington County Office of Community Services, Fidelis Care, Catholic Charities Domestic Violence Project, Comfort Food Community and the Council for Prevention for Warren and Washington County.

All the partners received copies of the previous reported data to review and copies of the current data available over the course of several meetings. Partners were then asked to review and comment via individual experience, discussion and the AHI Prioritization sheet Appendix J, what they felt the priority areas for the next three years should be. Partners were given the opportunity review and respond based on several criteria. These included: the severity of the problem based on data quartile scores, the Stakeholder survey data, Perceived community need based on the County resident data, funding available to work on the issue, availability of evidenced based interventions that make sense for the unique needs of the community, the capacity of stakeholders to address the need and implement potential interventions effectively and the effectiveness of current strategies , are there additional health benefits to be gained.

Once all partners had submitted their opinions, the information was compiled, and priorities were determined based on those recommendations. All the partners agreed that Preventing Chronic Disease and Promote Mental Health and Prevent Substance Abuse should be priorities for Washington County for the 2019-2021 community health improvement cycle.

For more information about how the Washington County CHNA workgroup plans on addressing these priorities please refer to the Washington County Community Health Improvement Plan.

2019-2021 Priorities and Goals:

1. **Preventing Chronic Disease**
    a. **Focus Area 3- Tobacco Prevention**
        i. **Goal 1 Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults.**
2. **Promote Mental Health and Prevent Substance Abuse**

a. Focus Area 2- Mental and Substance Use Disorders Prevention

i. Prevent opioid and other substance misuse and death

Disparity: **Income/poverty /Asset Limited, Income Constrained, Employed**

Washington County residents are disproportionately affected by a multitude of factors that contribute to inequities in health. The total population is 62,183, one quarter of the residents receive Medicaid (25.1%), 12.8% live below the federal poverty level and 30.4% of all households are Asset Limited, Income Constrained, Employed (ALICE). The burden of disease related to tobacco use, poor nutrition, lack of physical activity and poor mental health exceeds the NYS average in many categories. The same health factors adversely affect maternal child health and birth outcomes. In addition, Washington County is characterized by lower educational attainment, higher unemployment rates, higher disability rates, and lower incomes than our neighboring counties. Social Determinants such as these have proven to be very strong drivers of general health and well-being. Therefore, the primary disparity of concern is poverty, ALICE individuals in the community.

Assets and Resources that can be mobilized and employed to address the health issues identified.

Washington County Public Health Nursing Service is very fortunate to have a network of collaborative, engaged and concerned partners who want the best for the communities in which we all live, work, learn, play and age. We all understand that it is only by partnering and combining expertise and resources that we can make a collective positive impact on our communities. We all understand we have limited financial and human capital to invest and through partnership and mutual support can maximize our collective resources. It is a long-term commitment that no organization or its leadership takes lightly, as we also know that changing health and its drivers takes time, persistence and consistency.

We have a strong network of dedicated partners through the Adirondack Rural Health Network Community Health Assessment Committee and workgroup, our local services and program providers, school nurses and health care providers, the Washington County Healthy Communities Coalition as well as burgeoning relationships with recreation and business entities. We will rely on each other for communication and collaboration to address the prioritized issues. Relationships and collaboration our key resources we count on the make a difference.

The Adirondack Rural Health Network (ARHN), the longest-running program of AHI, originating in 1992, provides a forum for public health leaders, community health centers, hospitals, behavioral health organizations, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities. As a multi-stakeholder regional coalition, ARHN informs on planning assessment, provides education and training to further the NYS DOH Prevention Agenda and Delivery System Reform Incentive Payment (DSRIP) Program, and offers other resources that support the development of the regional health care system.

ARHN hosts quarterly meetings targeting health care professionals and other stakeholders from Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.

The ARHN Community Health Assessment (CHA) Committee is made up of representatives from thirteen hospitals and local public health departments from seven counties who contract each year with ARHN/AHI for community health assessment services. Representatives from Adirondack Health, Clinton County Health Department, Essex County Public Health, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital & Nursing Home, University of Vermont Health Network – Alice Hyde Medical Center, University of Vermont Health Network – Champlain Valley Physicians Hospital, University of Vermont Health Network – Elizabethtown Community Hospital, Warren County Health Services and Washington County Health Services are all committee members. Since 2002, ARHN **has coordinated this multi-county, regional**

stakeholder committee to support community health planning and assessment, including capacity development, provision of decision-making resources/tools and leveraging collaborative partnerships/resources to address identified regional priorities.

The Washington County Healthy Communities Coalition

Washington County has always taken pride in a long history of partnerships and collaborations. Due to limited resources, partnering with community-based organizations and other health agencies has always been a vital component to implementation of County run initiatives and programs for out constituents. In 2009 Washington County received a non-competitive grant which was used to develop a county wide coalition called the Washington County Healthy Communities Coalition. This coalition was formed with the hope of making Washington County a healthier place to live, work, learn and play. It is without saying that this coalition has played a very important role in the development of, evaluation and sustainability of health-related efforts grounded in the Community Health assessment and Community Health Improvement plan. This is now a decade old engagement process and partners have come and gone from the group. We have sustained the group since 2009 and it has played a key role in looking at the efforts that are being made to address health disparities and issues identified by the assessment process. We look to add members and are actively recruiting nontraditional members from outside the field of health to inform the group, especially regarding the social determinants of health. We rely on work of other groups and social service organizations to enhance the work and goals of the entire committee.

Washington County will continue to partner regionally and locally to evaluate processes and outcomes. Process evaluation will allow for review of activities success or need for correction. Outcome evaluation will provide an important measure of program results and effectiveness to assess if activity produced the intended outcomes. Coalition meetings allow local stakeholders to be included in and inform the action plan, goals and objectives of the CHIP. It also allows for information sharing and connection to complimentary activities and programs that may be beneficial to community health improvement. The overall goal is to harness all activities and programs to reduce redundancy and to best invest limited time and resources.

Dissemination

Washington County Public Health will publicize the Community Health Improvement Plan/Community Health Assessment executive summary and report on the Public Health website at https://washingtoncountyny.gov/292/Public-Health-Nursing

Washington County will direct individuals to the county website for information. If individuals do not have the ability to access data and plans on the internet, hard copies will be provided upon request.

Washington County reports will also be available alongside our regional and community partners on the Adirondack Health Institute's Health ADK data website at http://www.healthyadk.org/

See the "Explore by County" tab.

Appendices

Washington County
Public Health
Prevent. Promote. Protect.

Washington County NY Community Health Assessment and Improvement Plan 2019-2021
Executive Summary

The 2019 Washington County Community Health Assessment and Improvement Plan identifies needs and priorities in Health for Washington County NY.

We Participated with a variety of health care professionals, community-based organizations and interested parties in sharing data, information and goals. Washington County does not have a hospital located within it boarders, however we continue to partner with Glens Falls Hospital (GFH) in whose catchment area we lay and who many of our citizens rely on for medical care. In addition, we continue our regional partnerships facilitated by the Adirondack Rural Health Network (ARHN) a program of the Adirondack Health Institute (AHI).

The ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together utilizing a systematic approach to community health planning. The CHA Committee is made up of the following partners: Adirondack Health, Alice Hyde Medical Center, Elizabethtown Community Hospital, Essex County Public Health, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health Services, Moses Ludington Hospital & Inter-Lakes Health, Nathan Littauer Hospital, UVM Health Network – CVPH, Warren County Health Services, and Washington County Public Health Services.

The process of identifying the important health care needs of the residents of Washington County involved both data analysis and consultation with key members of the community. The data was

collected from multiple sources including publicly available health indicator data as well as the data collected from a stakeholder survey conducted by the Adirondack Rural Health Network & a Community Health Assessment Resident Survey conducted by Public Health in collaboration with ARHN.

The health indicator data is collected and published by New York State and contains nearly 300 different health indicators. Since 2002, The Adirondack Rural Health Network has been compiling this data for the region and producing reports to inform healthcare planning on a regional basis.

In April of 2019, the Adirondack Rural Health Network (ARHN) conducted a survey of selected stakeholders representing health care and service-providing agencies within an eight-county region. The results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels.

Using the results of the indicator analysis, the stakeholder and resident surveys, community assessments & other data sources cited, a group of stakeholders of the Washington County Healthy Communities Coalition was convened to identify and prioritize the current healthcare challenges for the residents of the County. The group Coalition consisted of representatives from Glens Falls Hospital and Community Based and other service organizations & elected officials in Washington County. The purpose was to provide a review of the indicators of health and get input from the diverse group as to the priorities to be chosen for continued collaboration and work. The group reviewed health indicator and prevention agenda priority data on four occasions. There was discussion as to what individuals were experiencing in the community,

among their clients and neighbors as well as service provision burden in the County. Consensus was reached through a prioritization process who methodology is outlined in the CHA.

The two (2) priority areas and specific focus areas for Washington County are listed below:

- **1. Chronic Disease:**
    - Focus Area 3- Tobacco Prevention
    - Goal 1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products by youth and young adults.
- **Promote Mental Health and Prevent Substance Abuse:**
    - Focus Area 2- Mental and Substance Use Disorders Prevention
    - Goal 1 Prevent opioid and other substance misuse and deaths

The overarching disparity of focus: Economic/Poverty/ Social Determinants of health.

Databases used for the Community Health Assessment

• Bureau of Communicable Disease Control Data • Bureau of HIV/AIDS Epidemiology Data • Cancer Registry • Community Health Indicator Reports • Division of Criminal Justice Services • Governor's Traffic Safety Committee Data Report • Motor Vehicle Crash Data • New York State Expanded Behavioral Risk Factor Surveillance System Data (BRFSS) • New York State Immunization Information System Data • New York State Medicaid Program Data • New York State Office of Mental Health Patient Characteristics Survey	• New York State Pregnancy Nutrition Surveillance System – WIC Program Data • Office of Mental Health County Profiles Data • Statewide Planning and Research Cooperative System (SPARCS) data • Vital Statistics Data • County Health Rankings and Roadmaps • Community Health Commons, Community Health Needs Assessment for Washington County • ALICE. Asset Limited, Income Constrained, Employed Study of Financial Hardship. United Way of New York State. • 2019 Stakeholder Survey • 2019 Washington County Community Health Assessment Resident Survey.

Washington Healthy Communities Coalition Partners

Allison Reynolds –Council for Prevention.	Gina Cantinucci-Mitchell-ADRC-OFA.	Robert York-Mental Health Director.
Brandi Bishop- GFH	Jeanne Noordsey-DVCCC Catholic Charities.	Sue Mowrey -Youth Bureau Alternative Sentencing.
Bob Shay HHS committee.	Emily Walter-GFH	Stephanie Ball-ADRC
Kathryn Cramer-GFH	Elizabeth Hoffman-GFH	Amelia Gelnett – Comfort Food Community
Chrys Nestle –CCE	Cathleen Traver- GFH	Devin Bulger- Comfort Food Community
Courtney Shaler-AHI AHRN	Leah Breeyear-Planned Parenthood.	Patty Hunt –Public Health
Sara Duekmejian- AHI ARHN	Nancy Tracky-DA office	Kathy McIntyre-Public Health
Rebecca Evansky-AHI	Pat Rozelle-WIC	Elizabeth St. John –Public Health
Sara Bayliss – AHI	Theresa DePaul-Fidelis Care	Susan McNeil- AHI
Traves Bethel -AHI PHIP	Marissa Joseph-Fidelis Care	
Tina VanGuilder-AHI		

Summary of Evidenced Based Strategies

GFH Creating Health Schools and Communities	Too Good for Drugs Program
Complete Streets	SBIRT screening
SMART growth policies	ACES
Creating Breastfeeding Friendly Communities	Trauma Informed Care
GFH-Living Tobacco Free Initiative	Bridges Out of Poverty
Mobile Integrated Health –Falls Prevention	Safe Harbor Initiatives
Tai Chi for Arthritis	Suicide Postvention Efforts
Mental Health First Aid	Integration of Behavioral Health and Primary Care.
Early Childhood Home Visitation.	3-4-50 interventions

Contacts:

Washington County Public Health, 415 Lower Main St. Hudson Falls NY, 12839

Patricia C. Hunt RN BSN MPH Director of Public Health, 518-746-2400

Kathy Jo McIntyre RN BSN Assistant Director of Public Health, 518-746-2400

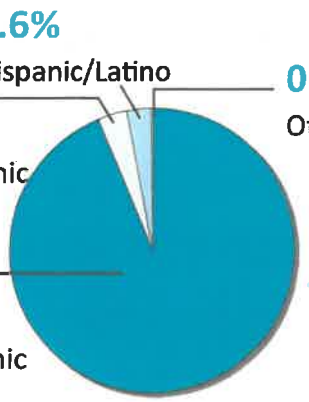
Glens Falls Hospital Health Promotion Center, Park St. Glens Falls NY 12801

Cathleen Traver, MPH CHES, Research and Planning, 518-926-6899

Please see the Washington County Community Health Improvement Work plan for detail on evidenced base interventions, strategies, community partner engagement and process measures.

WASHINGTON COUNTY | DATA SNAPSHOT

POPULATION



Under 18	12,167
Ages 18-64	38,982
Ages 65+	11,034

HOUSEHOLDS

Mean Household Income	$65,798
% Single Parent Households	9.3%

EMPLOYMENT STATUS

% Unemployed	3.9%

SCHOOL SYSTEM INFORMATION

Student-to-Teacher Ratio	10.8
% Free and Reduced Lunch	48.0%
% High School Graduate/GED	39.2%
% Some College, No Degree	18.7%
% Associate's Degree	10.7%
% Bachelor's Degree or Higher	19.8%

AVAILABILITY OF VEHICLES

% Households with One Vehicle or Less Available
40.0%

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs	1
Number of Dental Care HPSAs	1
Number of Mental Health HPSAs	2

POVERTY

% Individuals Receiving Medicaid	25.1%
% Individuals Under Federal Poverty Level	12.8%
Number of ALICE and Poverty Households	10,204

DATA SOURCES

The information above is comprised of a blending of multiple data sources, including: Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014; Centers for Medicare and Medicaid Services, CMS Enterprise Portal; Community Health Indicator Reports; Department of Health, Wadsworth Center; Division of Criminal Justice Services Index, Property, and Firearm Rates; Health Resources and Services Administration, HPSA Find, 2017-2018; Institute of Education Sciences, National Center for Education Statistics, 2016-2017; NYS Department of Health; NYS Department of Health Hospital Report on Hospital Acquired Infections; NYS Department of Health Tobacco Enforcement Compliance Results; NYS Education Department; NYS Expanded Behavioral Risk Factor Surveillance System; NYS Office of the Professions, License Statistics, 2019; NYS Traffic Safety Statistical Repository; Prevention Agenda Dashboard; State and County Indicators for Tracking Public Health Priority Areas; Student Weight Status Category Reporting System (SWSCRS) Data; United For ALICE; US Census Bureau, American Community Survey 5-year Estimates; US Department of Agriculture, National Agriculture Statistics Service, 2012; USDA Economic Research Service Fitness Facilities Data. **This document was created in 2019.**

Community Health Assessment Committee
2019 Data Methodology

Background:

The Community Health Assessment (CHA) Committee, facilitated by the Adirondack Rural Health Network (ARHN), a program of Adirondack Health Institute (AHI), is a multi-county, regional stakeholder group, that convenes to support ongoing health planning and assessment by working collaboratively on interventions, and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service to advance the New York State Prevention Agenda.

The overall goal of collecting and providing this data to the CHA Committee was to provide a comprehensive picture of the individual counties and overview of population health within the ARHN region, as well as Montgomery and Saratoga counties.

Demographic Profile:

Demographic data was primarily taken from the 2013-2017 American Consumer Survey 5-year estimates, utilizing the United States Census Bureau American FactFinder website. Other sources include the 2010-2014 American Consumer Survey 5-year estimates, Centers for Medicaid and Medicare Services, through the CMS Enterprise Portal, NYS Department of Health, U.S. Department of Agriculture (USDA), and the National Agriculture Statistics Service.

Information incorporated into the demographic report includes square mileage, population, family structure and status, household information, education and employment status.

Health System Profile:

The vast majority of health systems data comes from the New York State Department of Health, including the NYS Health Profiles, Nursing Home Weekly Bed Census, License Statistics and Adult Care Facility Directory. Other sources include Health Resources and Services Administration (HRSA) and Center for Health Workforce Studies, Health Workforce Planning Data Guide.

Health system profile data incorporated hospital, nursing home, and adult care facilities bed counts, health professional shortage areas (HPSAs), physician data, and licensure data.

Education Profile:

The education profile is separated into two parts; education system information and school districts by county. Part one of the education profiles includes data pertaining to education systems in the ARHN region, including student teacher ratios, english proficiency rates, and free lunch eligibility rates as well as available education programs and graduates. Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies. Part two identifies school districts by county includes county school districts as well as regional school districts.

Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies.

ALICE Profile:

All data provided in the ALICE profile comes from the 2016 ALICE report, which can be found at www.unitedforalice.org/new-york. Sources utilized in the report include American Consumer Survey, Bureau of Labor Statistics, Consumer Reports, IRS and U.S. Department of Agriculture.

In April 2018, the NYS Department of Health released guidance for 2019-2021 community health assessment and planning. It was suggested that local health departments and hospitals submit one plan per county and hospitals serving more than one county were strongly encouraged to select and prioritize high poverty neighborhoods for action. To address these updates, the Asset Limited, Income Constrained, Employed (ALICE) profile was added. ALICE profile data includes total households, , poverty and ALICE percentages, unemployment rates, percent of residents with health insurance and average annual earnings. Please note that all data on the ALICE profile is reflective of 2016 figures.

Data Sheets:

The data sheets, compiled of 271 data indicators, provide an overview of population health as compared to the ARHN region, Upstate New York and New York State. The reports feature a status field that specifies whether indicators were met, better, or worse than their corresponding benchmarks. When indicators were worse than their corresponding benchmarks, their distances from their respective benchmarks were calculated. On the report, distances from benchmarks were indicated using quartile rankings.

Quartile 1: Less than 25%	Quartile 3: 50% - 74.9%
Quartile 2: 25% - 49.9%	Quartile 4: 75% - 100%

The report also showed the percentage of total indicators that were worse than their respective benchmarks by focus area.

- For example, if 20 of the 33 child health focus area indicators were worse than their respective benchmarks, the quartile summary score would be 61% (20/33).
- Additionally, the report identified a severity score, i.e., the percentage of those indicators that were either in quartile 3 or 4. Using the above example, if 9 of the 20 child health focus indicators that were worse than their respective benchmarks were in quartiles 3 or 4, the severity score would be 45% (9/20).

Quartile summary scores and severity scores were calculated for each focus area as well as for Prevention Agenda indicators and "other indicators" within each focus area. Both quartile summary scores and severity scores were used to understand if the specific focus areas were challenges to the counties and hospitals. In certain cases, focus areas would have low severity scores but high quartile summary scores indicating that while not especially severe, the focus area offered significant challenges to the community.

Indicators were broken out by the Prevention Agenda focus areas, across ten tabs. Tabs include *Mortality, Injuries, Violence and Occupational Health, Built Environment and Water, Obesity, Smoke Exposure, Chronic Disease, Maternal and Infant Health, HIV, STD, Immunization and Infections*

Substance Abuse and Mental Health, and *Other.* Data and statistics for all indicators comes from a variety of sources, including:

- Prevention Agenda Dashboard
- Community Health Indicator Reports (CHIRs)
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- NYS Traffic Safety Statistical Repository
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data
- NYS Department of Health Tobacco Enforcement Compliance Results
- State and County Indicators for Tracking Public Health Priority Areas
- NYS Department of Health, Asthma Dashboard – County Level
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- NYS Office of Mental Health, PCS

Appendix A: Demographic Profile

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS	New York State
Summary of Demographic Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Square Miles[1,2]												
Total Square Miles[1]	1,037.9	1,794.2	1,629.1	495.5	1,717.4	403.0	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Total Square Miles for Farms[1]	230.0	85.7	226.6	49.8	3.2	205.3	123.2	14.9	295.9	906.1	11,223.6	11,224.3
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	50.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile[2]	78.12	21.24	30.94	108.64	2.64	122.26	280.32	74.48	74.35	42.5	239.4	418.9
Population[3]												
Total Population	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White, Non-Hispanic	91.0%	92.8%	82.5%	94.7%	97.9%	88.2%	93.2%	96.0%	98.5%	92.8%	79.8%	63.8%
Percent Black, Non-Hispanic	4.2%	3.2%	5.9%	1.8%	2.6%	1.8%	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Percent Hispanic/Latino	2.8%	3.2%	3.4%	2.8%	1.5%	13.2%	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Percent Asian/Pacific Islander, Non-Hispanic	1.5%	0.5%	0.6%	0.7%	0.4%	0.8%	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
Percent Alaskan Native/American Indian	0.2%	0.2%	6.9%	0.3%	1.0%	0.1%	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Multi-Race/Other	1.5%	3.3%	3.9%	2.4%	2.5%	9.1%	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
Number Ages 0-4	3,827	1,538	2,478	2,270	148	3,054	11,787	2,902	3,051	16,214	616,519	1,176,877
Number Ages 5-14	8,388	3,544	5,493	6,322	377	6,273	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	2,411	1,373	2,041	2,049	131	1,999	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	53,326	23,602	33,133	33,062	2,708	29,322	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	13,028	8,176	7,909	9,802	1,282	8,852	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Number Ages 15-44 Female	14,990	13,125	8,289	9,272	569	8,805	41,090	10,793	10,096	67,134	2,091,141	4,027,930
Family Status[3]												
Number of Households	31,680	15,257	18,956	22,535	19,700	1,095	93,129	27,249	23,988	159,365	4,160,305	7,302,710
Percent Families Single Parent Households	9.9%	7.9%	10.8%	10.7%	11.3%	n/a	6.7%	7.8%	9.3%	9.7%	9.9%	8.9%
Percent Households with Grandparents as Parents	12.5%	24.8%	5.2%	12.1%	5.4%	9.7%	15.2%	9.2%	8.6%	10.7%	27.3%	19.6%
Poverty[2,3]												
Mean Household Income	$ 65,435	$ 69,488	$ 62,870	$ 61,941	$ 64,039	$ 62,118	$ 96,086	$ 76,756	$ 65,798	$ 66,618	n/a	$ 93,443
Per Capita Income	$ 25,833	$ 29,008	$ 24,294	$ 26,298	$ 24,891	$ 25,307	$ 39,653	$ 33,127	$ 26,064	$ 27,377	$ 40,926	$ 35,752
Percent of Individuals Under Federal Poverty Level	15.7%	8.9%	19.4%	16.0%	9.7%	19.6%	6.6%	9.9%	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	23.2%	20.4%	24.6%	25.0%	22.6%	29.7%	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Per Capita Medicaid Expenditures[3]	$ 8,574	$ 8,028	$ 7,383	$ 9,148	$ 7,060	$ 9,069	$ 8,397	$ 8,283	$ 8,493	n/a	n/a	$ 9,670
Immigrant Status[2,4]												
Percent Born in American Territories	95.4%	96.9%	95.3%	97.9%	97.1%	96.4%	94.5%	96.3%	97.8%	96.5%	87.7%	76.0%
Percent Born in Other Countries	4.6%	3.1%	4.7%	2.1%	2.9%	3.6%	5.5%	3.7%	2.2%	3.5%	12.3%	24.0%
Percent Speak a Language Other Than English at Home[4]	5.5%	5.9%	7.5%	3.3%	5.6%	14.3%	6.9%	5.2%	3.3%	5.1%	31.2%	30.6%
Housing[3]												
Total Housing Units	36,352	26,114	25,582	29,004	8,885	23,480	103,766	39,559	29,367	194,863	4,164,398	8,255,911
Percent Housing Units Occupied	87.1%	58.4%	74.1%	77.7%	12.3%	83.9%	89.7%	68.9%	81.7%	72.2%	57.0%	88.5%
Percent Housing Units Owner Occupied	68.0%	76.0%	72.9%	71.4%	84.7%	68.9%	71.5%	71.9%	72.7%	71.8%	74.7%	54.0%
Percent Housing Units Renter Occupied	32.0%	24.0%	27.1%	28.6%	15.3%	31.1%	28.5%	28.1%	27.3%	28.2%	38.7%	46.0%
Percent Built Before 1970	45.2%	57.5%	54.2%	64.6%	55.9%	72.8%	34.2%	46.9%	55.8%	53.3%	92.2%	68.0%
Percent Built Between 1970 and 1979	14.6%	10.5%	11.6%	9.7%	11.6%	7.7%	14.1%	11.9%	10.8%	11.7%	70%	10.0%
Percent Built Between 1980 and 1989	14.7%	11.0%	12.1%	8.8%	11.0%	6.8%	16.2%	14.6%	11.6%	12.3%	74.1%	7.6%
Percent Built Between 1990 and 1999	13.5%	8.9%	12.5%	8.9%	11.9%	6.8%	15.2%	11.9%	9.9%	11.1%	75.3%	6.1%
Percent Built 2000 and Later	12.0%	12.2%	9.8%	8.0%	9.6%	5.7%	20.2%	14.7%	11.9%	11.6%	69.9%	8.2%
Availability of Vehicles[3]												
Percent of Households with No Vehicles Available	9.3%	7.5%	9.5%	9.4%	4.8%	12.7%	4.4%	9.0%	6.3%	8.5%	19.2%	29.0%
Percent of Households with One Vehicle Available	33.6%	32.7%	35.0%	36.5%	31.9%	34.4%	31.9%	35.4%	33.7%	34.5%	58.4%	32.8%
Percent of Households with Two Vehicles Available	37.1%	40.7%	40.1%	37.2%	47.5%	34.7%	43.6%	38.0%	39.3%	38.6%	82.1%	26.2%
Percent of Households with Three or More Vehicles Available	19.9%	19.2%	15.4%	16.9%	15.8%	18.2%	20.0%	17.7%	20.7%	18.4%	89.4%	12.0%
Education[3]												
Total Population Ages 25 and Older	55,125	28,866	35,862	38,651	3,604	34,126	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	13.3%	9.1%	13.7%	13.0%	12.2%	14.8%	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	37.1%	33.3%	37.2%	35.7%	32.0%	35.3%	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.9%	20.2%	18.6%	20.0%	23.5%	19.3%	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	9.9%	10.7%	11.8%	13.6%	12.2%	13.6%	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	11.2%	14.5%	9.0%	9.8%	8.7%	10.1%	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	10.6%	12.2%	9.6%	7.9%	11.3%	6.9%	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status[3]												
Total Population Ages 16 and Older	68,228	32,769	42,189	44,129	4,079	39,440	185,143	54,254	51,620	297,268	9,126,563	16,080,981
Total Population Ages 16 and Older in Armed Forces	26	10	9	7	1	39	1,563	6	50	109	20,938	23,203
Total Population Ages 16 and Older in Civilian Workforce	38,304	18,796	21,744	26,241	2,243	23,696	122,689	34,150	30,756	172,234	5,737,902	10,152,999

Employment Sector												
Percent Unemployed	3.2%	3.8%	4.2%	4.5%	6.2%	4.4%	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%
Total Employed	36,091	17,544	19,960	24,239	1,991	21,956	117,053	32,518	28,741	161,084	5,394,792	9,467,631
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.3%	3.2%	3.1%	0.9%	0.7%	2.2%	0.8%	0.6%	4.0%	2.2%	1.0%	0.6%
Percent in Construction	4.8%	8.2%	6.6%	6.4%	18.5%	6.9%	6.1%	6.8%	8.2%	6.8%	6.1%	5.6%
Percent in Manufacturing	12.3%	8.7%	5.0%	12.3%	6.8%	13.6%	10.5%	8.4%	14.0%	10.5%	8.3%	6.2%
Percent in Wholesale Trade	1.8%	1.2%	1.4%	1.8%	4.7%	2.2%	2.4%	2.6%	1.7%	1.9%	2.6%	2.4%
Percent in Retail Trade	13.3%	11.6%	10.5%	15.3%	9.3%	13.9%	12.1%	13.3%	14.3%	13.2%	11.4%	10.6%
Percent in Transportation, Warehousing, Utilities	4.9%	3.2%	2.8%	5.7%	10.4%	5.3%	3.2%	3.8%	4.6%	4.4%	4.5%	5.2%
Percent in Information Services	1.9%	1.7%	1.2%	1.5%	1.3%	1.1%	1.8%	1.4%	0.9%	1.4%	2.2%	2.9%
Percent in Finance	2.8%	3.9%	3.2%	2.9%	2.0%	4.4%	7.0%	5.2%	4.3%	3.7%	7.0%	8.1%
Percent in Other Professional Occupations	5.2%	5.1%	5.5%	7.1%	5.0%	6.7%	11.9%	8.3%	7.4%	6.5%	10.6%	11.8%
Percent in Education, Health Care and Social Assistance	26.7%	29.1%	33.2%	27.2%	22.9%	26.4%	25.1%	26.6%	23.0%	27.1%	28.2%	27.5%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.8%	13.6%	10.4%	7.8%	7.4%	6.5%	8.7%	12.7%	7.8%	10.4%	8.6%	9.6%
Percent in Other Services	3.8%	4.2%	4.3%	4.7%	2.9%	4.1%	3.7%	4.8%	4.2%	4.3%	4.7%	5.0%
Percent in Public Administration	9.6%	6.3%	12.8%	6.3%	8.2%	6.8%	6.6%	5.5%	5.6%	7.6%	5.1%	4.5%

(n/a) Data Not Available

Sources:

(1) US Department of Agriculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medicaid Services, CMS Enterprise Portal

(4) US Census Bureau, 2010-2014 American Community Survey 5-year Estimates

(5) US Census Bureau, 2013-2017 American Community Survey 5-year Estimates

Appendix B: Health Systems Profile

Adirondack Rural Health Network	County									ARHN	Upstate NYS	New York
Summary of Health Systems Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region		State
Population, 2013-2017	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996	11,238,156	19,798,228
Total Hospital Beds[1]												
Hospital Beds per 100,000 Population	369.3	65.4	334.9	137.2	n/a	262.6	75.5	627.5	n/a	274.2	n/a	n/a
Medical/Surgical Beds	214	0	129	47	n/a	70	115	300	n/a	690.0	n/a	n/a
Intensive Care Beds	14	0	14	8	n/a	5	12	12	n/a	48.0	n/a	n/a
Coronary Care Beds	7	0	0	0	n/a	3	7	12	n/a	19.0	n/a	n/a
Pediatric Beds	10	0	3	12	n/a	0	7	14	n/a	39.0	n/a	n/a
Maternity Beds	21	0	13	7	n/a	8	14	23	n/a	64.0	n/a	n/a
Physical Medicine and Rehabilitation Beds	0	0	0	0	n/a	10	0	15	n/a	15.0	n/a	n/a
Psychiatric Beds	34	0	12	0	n/a	20	16	30	n/a	76.0	n/a	n/a
Other Beds	0	25	0	0	n/a	14	0	0	n/a	25.0	n/a	n/a
Hospital Beds Per Facility[1]												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	-	-	-
Alice Hyde Medical Center	-	-	76	-	-	-	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center	300	-	-	-	-	-	-	-	-	-	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	-	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	406	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds[2]												
Nursing Home Beds per 100,000 Population	603.3	889.3	381.9	667.2	0.0	1191.9	317.3	616.7	849.1	-	-	-
Nursing Home Beds per Facility[2]												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	-	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	-	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	-	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	82	-	-	-	-
Elderwood at Ticonderoga	-	84	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	196	-	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	-	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	-	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	-	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	-	-	-
Mercy Living Center	-	-	60	-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	-	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	89	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Saratoga Center for Rehab and Skilled Nursing Care	-	-	-	-	-	-	257	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	-	-	-
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-	-	-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	-	-	-
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	-	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds[3]												
Adult Care Facility Beds per 100,000 Population	221.6	928.5	176.3	307.7	0.0	977.8	390.1	452.9	403.6	375.0	550.2	404.7
Total Adult Home Beds	150	194	60	114	n/a	294	483	248	142	908	38,328	49,670
Total Assisted Living Program Beds	30	30	30	52	n/a	160	0	45	69	256	7,072	12,192
Total Assisted Living Residence (ALR) Beds	0	131	0	0	n/a	30	401	0	40	171	16,434	18,255
Adult Home Beds by Total Capacity per Facility[3]												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	-	-	-

Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	-	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	-	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	-	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Beacon Pointe Memory Care Community	-	-	-	-	-	-	52	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	-	-	-
Cook Adult Home	-	-	-	-	-	-	13	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Emeritus at the Landing of Queensbury	-	-	-	-	-	-	-	88	-	-	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	-	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	-	-	-
Pine Harbour	66	-	-	-	-	-	-	-	-	-	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	-	-	-
Samuel F. Vilas Home	44	-	-	-	-	-	-	-	-	-	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	-	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	-	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	34	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Health Professional Shortage Areas (HPSAs)[4,5]												
Number of Primary Care HPSAs[4]	1	8	5	1	2	1	0	3	1	21	111	181
Primary Care HPSA Population[5]	10,339	4,481	5,997	13,950	2,949	11,456	0	2,168	189	40,073	n/a	n/a
Number of Dental Care HPSAs[4]	1	3	5	1	0	1	0	1	1	12	87	139
Dental Care HPSA Population[5]	0	6,368	16,181	0	0	0	0	0	0	22,549	n/a	n/a
Number of Mental Health HPSAs[4]	2	3	2	1	1	1	0	2	2	13	96	159
Mental Care HPSA Population[5]	10,339	39,309	51,698	6,698	4,835	11,456	0	0	0	112,879	n/a	n/a
Population, 2013-2017[5]												
Primary Care Physicians per 100,000 population	119.2	66.2	101.9	99	84.9	83.9	87.5	153	66.4	n/a	102.8	124.1
Subspeciality per 100,000 population												
Obstetrics/Gynecology	14.9	0.0	18.3	7.4	0.0	5.4	8.4	18.6	0.0	n/a	11.0	14.5
IM Subspeciality	34.8	7.0	13.1	9.9	0.0	37.9	21.1	60.0	0.0	n/a	31.8	49.8
General Surgery	6.6	3.5	10.5	9.9	0.0	2.7	3.6	12.4	2.1	n/a	7.9	8.8
Surgical Subspecialties	23.2	10.5	0.0	7.4	0.0	8.1	10.9	37.2	0.0	n/a	17.8	21.6
General Psychiatry	24.8	0.0	15.7	9.9	0.0	8.1	21.1	20.7	8.6	n/a	18.8	36
Other	107.6	20.9	65.3	32.2	56.6	56.9	33.8	159.2	4.3	n/a	87.8	121.1
Total Physician[5]												
Total Physician per 100,000 population	317.9	108.0	206.5	168.3	141.5	200.4	179.2	442.5	81.4	n/a	268.0	362.9
Licensure Data[6]												
Clinical Laboratory Technician	14	6	5	1	0	4	21	9	5	40	1,208	1,649
Clinical Laboratory Technologist	54	19	27	32	1	38	161	50	24	207	7,730	12,064
Dental Assistant	11	2	9	4	0	7	33	10	11	47	1,338	1,435
Dental Hygienist	42	15	16	23	2	26	241	44	38	180	8,035	10,428
Dentist	41	14	17	17	1	25	175	46	15	151	8,771	15,075
Dietition/Nutritionist, Certified	21	9	8	4	1	10	122	22	7	72	3,667	5,492
Licensed Clinical Social Worker (R/P psycotherapy)	42	24	31	21	2	15	266	72	35	227	14,629	25,254
Licensed Master Social Worker (no privileges)	34	22	26	18	2	23	267	53	26	181	14,861	26,884
Licensed Practical Nurse	382	215	321	308	10	362	895	335	438	2,009	48,582	63,082
Physician	211	49	85	59	6	87	528	265	36	711	42,475	75,565
Mental Health Counselor	59	20	32	10	1	13	147	32	13	167	4,647	6,853
Midwife	6	1	3	4	0	2	14	12	5	31	595	1,022
Nurse Practitioner	79	13	36	38	2	27	258	94	29	291	15,282	22,128

Pharmacist	106	29	41	36	2	40	484	64	44	322	13,780	21,306
Physical Therapist	64	40	48	30	3	43	395	67	30	282	13,417	19,277
Physical Therapy Assistant	17	10	18	20	0	26	55	27	16	108	3,988	5,518
Psychologist	11	15	8	10	1	5	109	28	4	77	6,018	11,519
Registered Physician Assistant	43	30	34	21	3	19	199	88	17	236	9,154	13,640
Registered Professional Nurse	1,270	494	744	643	57	714	3,769	1,145	755	5,108	172,978	243,639
Respiratory Therapist	18	3	6	17	0	18	110	21	13	78	4,107	5,763
Respiratory Therapy Technician	6	0	2	2	0	1	12	4	3	17	579	747

(n/a) Data Not Available

Sources:

(1) NYS Department of Health, NYS Health Profiles

(2) NYS Department of Health, Nursing Home Weekly Bed Census, 2018

(3) NYS Department of Health, Adult Care Facility Directory

(4) Health Resources and Services Administration, HPSA Find, 2017-2018

(5) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

(6) NYS Office of the Professions, License Statistics, 2019

Appendix C: Education System Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York
Summary of Education System Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	NYS	State
School System Information[1,2,3]												
Total Number of Public School Districts	9	11	8	6	5	6	12	9	12	60	725	733
Total Pre-K Enrollment	250	188	335	377	27	432	399	137	344	1,658	51,063	122,681
Total K-12 Enrollment	10,599	3,618	7,158	7,423	401	7,254	33,329	8,743	8,311	46,253	1,604,870	2,629,970
Number of Students Eligible for Free Lunch	4,410	1,533	3,594	3,504	141	3,869	6,646	3,158	3,511	19,851	592,339	1,263,175
Number of Students Eligible for Reduced Lunch	521	290	471	320	32	310	959	321	477	2,432	69,464	131,974
Percent Free and Reduced Lunch	47.0%	50.0%	57.0%	51.0%	43.0%	57.0%	23.0%	40.0%	48.0%	46.5%	40.0%	53.0%
Number Limited English Proficiency[2]	1,259	636	546	965	75	848	6,718	1,684	1,356	6,521	220,797	437,130
Percent with Limited English Proficiency[2]	42.0%	43.0%	25.0%	33.0%	45.0%	30.0%	55.0%	48.0%	42.0%	13.6%	13.3%	45.0%
Total Number of Graduates	774	273	505	514	27	474	2,531	688	561	3,342	116,704	179,863
Number Went to Approved Equivalency Program	1	0	2	0	n/a	3	9	21	5	29	1,097	2,653
Number Dropped Out of High School	78	18	48	89	n/a	112	176	38	94	365	10,670	21,368
Percent Dropped Out of High School	2.0%	2.0%	2.0%	4.0%	n/a	5.0%	2.0%	1.0%	4.0%	0.8%	0.64%	3.0%
Total Number of Public School Teachers[3]	1,008.9	422.0	701.9	602.8	89.5	627.1	2,277.3	784.2	813.8	4,422.9	132,652.7	209,093.4
Student to Teacher Ratio[3]	10.9	9.1	10.7	13.3	4.9	12.6	13.4	11.4	10.8	10.97	12.37	13.05
Education Programs[4]												
Medical Resident Programs	0	0	0	0	0	0	0	0	0	0	203	967
Medical Resident Graduations/Completions	0	0	0	0	0	0	0	0	0	0	920	5,790
Physician Assistant Programs	0	0	0	0	0	0	0	0	0	0	7	27
Physician Assistant Graduations/Completions	0	0	0	0	0	0	0	0	0	0	103	764
Nurse Practitioner Programs	0	0	0	0	0	0	0	0	0	0	24	58
Nurse Practitioner Graduations/Completions	0	0	0	0	0	0	0	0	0	0	249	725
Pharmacist Programs	0	0	0	0	0	0	0	0	0	0	3	6
Pharmacist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	398	913
Dental Hygienist Programs	0	0	0	0	0	0	0	0	0	0	7	13
Dental Hygienist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	197	429
Licensed Practical Nursing Programs	1	1	0	0	0	1	1	0	0	2	36	52
Licensed Practical Nurse Graduations/Completions	23	23	0	0	0	26	70	0	0	46	2,186	3,369
Registered Nursing Programs	2	2	0	0	0	1	1	1	0	5	68	118
Registered Nurse Graduations/Completions	93	93	0	0	0	32	19	86	0	272	4,606	10,192
Social Worker Programs	0	0	0	0	0	0	0	0	0	0	7	22
Social Worker Graduations/Completions	0	0	0	0	0	0	0	0	0	0	645	3624

(n/a) Data Not Available

Sources:

(1) NYS Education Department, School Report Card Data, 2016-2017

(2) NYS Education Department, 3-8 ELA Assessment Data, 2017-2018

(3) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

(4) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

Adirondack Rural Health Network
Summary of Education System Information
School District by County[1]

Clinton	Essex	Franklin	Fulton	Hamilton
Ausable Valley	Crown Point	Brushton-Moira	Broadalbin-Perth	Indian Lake
Beekmantown	Elizabethtown-Lewis	Chateaugay	Gloversville	Inlet
Chazy	Keene	Franklin-Essex-Hamilton BOCES	Johnstown	Lake Pleasant
Clinton-Essex-Warren-Washington BOCES	Lake Placid	Malone	Mayfield	Long Lake
Northeastern Clinton	Minerva	Saint Regis Falls	Northville	Wells
Northern Adirondack	Moriah	Salmon River	Wheelerville	
Peru	Newcomb	Saranac Lake		
Plattsburgh	Schroon Lake	Tupper Lake		
Saranac	Ticonderoga			
	Westport			
	Willsboro			

Montgomery	Saratoga	Warren	Washington
Amsterdam	Ballston Spa	Bolton	Argyle
Canajoharie	Corinth	Glens Falls City	Cambridge
Fonda-Fultonville-Fort Plain	Edinburg	Glens Falls Common	Fort Ann
Hamilton-Fulton-Montgomery BOCES	Galway	Hadley-Luzerne	Fort Edward
Oppenheim-Ephratah-St.Johnsville	Mechanicville	Johnsburg	Granville
	Niskayuna	Lake George	Greenwich
	Saratoga Springs	North Warren	Hartford
	Schuylerville	Queensbury	Hudson Falls
	Shenendehowa	Warrensburg	Putnam
	South Glens Falls		Salem
	Stillwater		Washington BOCES
	Waterford-Halfmoon		Whitehall

*Gray highlighting indicates a regional school district

(n/a) Data Not Available

Sources:

(1) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

Appendix D: ALICE Profile

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	County									ARHN	Upstate NY	NYS
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
ALICE Household Information												
Total Households	30,624	15,298	19,299	22,450	1,239	19,540	93,703	28,841	24,027	141,778	4,101,529	7,216,340
Total Households Over 65 Years of Age	8,150	5,144	4,817	6,339	544	5,484	24,083	8,898	6,738	40,630	705,081	1,839,483
Total ALICE Households	7,350	4,589	5,404	6,511	632	6,448	19,678	6,922	7,208	38,615	1,059,036	2,222,633
ALICE Households Over 65 Years of Age	2,119	1,749	1,590	2,282	261	2,468	6,502	2,936	2,291	13,408	380,182	662,214
Poverty %	15.0%	10.2%	18.2%	15.0%	12.2%	17.6%	6.8%	11.0%	12.1%	13.6%	11.3%	14.4%
ALICE %	24.4%	30.1%	27.8%	29.3%	50.7%	33.2%	21.1%	24.0%	30.4%	27.4%	28.7%	30.8%
Above ALICE %	60.6%	59.7%	54.0%	55.7%	37.1%	49.2%	72.1%	65.1%	57.5%	59.0%	60.0%	54.8%
# of ALICE and Poverty Households	12,062	6,161	8,869	9,945	779	9,928	26,181	10,079	10,204	58,099	1,640,619	3,262,043
Unemployment Rate	5.0%	7.5%	8.5%	8.0%	9.2%	8.4%	2.9%	4.6%	8.1%	n/a	n/a	n/a
Percent of Residents with Health Insurance	95.8%	93.2%	91.3%	91.4%	90.4%	91.2%	96.1%	96.5%	91.9%	n/a	n/a	n/a
Average Annual Earnings	$36,372.00	$37,128.00	$35,148.00	$32,892.00	$32,940.00	$37,704.00	$47,604.00	$40,932.00	$38,028.00	n/a	n/a	n/a
ALICE Households by Race/Ethnicity												
White	8,119	4,449	5,191	6,683	622	6,112	19,596	6,635	7,404	39,103	922,506	1,245,865
Asian	50	n/a	2	28	n/a	28	191	65	27	172	31,141	180,688
Black	122	n/a	13	32	n/a	134	255	100	14	281	125,980	433,433
Hispanic	81	33	41	156	n/a	651	425	126	200	637	134,063	494,216
2+ races	95	49	44	71	n/a	79	278	38	64	361	22,672	54,130

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).

*Data in all categories except *Two or More Races* is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.

(n/a) Data Not Available

Sources:

(1) American Community Survey, 2016.

ALICE Demographics:

(2) American Community Survey and the ALICE Threshold, 2016.

Wages:

(3) Bureau of Labor Statistics, 2016

Budget:

(4) Bureau of Labor Statistics, 2016a; Consumer Reports, 2017; Internal Revenue Service, 2016

(5) New York State Office of Children & Family Services, 2016; Tax Foundation, 2016, 2017; U.S. Department of Agriculture; U.S. Department of Housing and Urban Development

Appendix E

ADIRONDACK RURAL HEALTH NETWORK 2019 MEETINGS

Meetings held quarterly, 10:30-11:45 a.m.

Friday, March 8, 2019
Lake George Holiday Inn

Tuesday, June 11, 2019
Lake George Holiday Inn

Friday, September 6, 2019
Great Escape Lodge

Friday, December 6, 2019
***Virtual Webinar Meeting**

Meetings open to all organizations who are interested in improving the health and well-being of our rural residents.

Attendees include regional leaders of public health, community health centers, hospitals, behavioral health organizations, emergency medical services and other community-based organizations.

Meeting agendas include:

* A partner presentation;
* Roundtable sharing of regional population health news;
* Networking time.

To be added to the invite list, please email ARHN Manager Courtney Shaler at cshaler@ahihealth.org, or call 518-480-0111, ext. 304.

ARHN is a program of AHI.

Adirondack Rural Health NETWORK

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Appendix F:

Washington County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				23.7%	22.8%	22.4%	24.0%	**21.8%**	Worse	X					
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				2.97+	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.36+	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				153.2	N/A	116.80	124.00	**122.0**	Worse	X					
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.55+	N/A	2.04	2.07	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.66+	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				93.5%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				94.2%	N/A	84.4%	82.6%	**90.8%**	Better						
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	608	592	629	981.2	990.5	877.4	769.8	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, 2016				3,541.1	4,866.3	**3,865.6**	4,169.1	N/A	Better						
3. Rate of Total Hospitalizations per 10,000 Population, 2016				1,146.0	1,039.9	**1,125.3**	1,154.4	N/A	Better						
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				10.7%	9.9%	**9.8%**	11.2%	N/A	Worse	X					
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				15.8%	14.3%	**12.0%**	11.3%	N/A	Worse	X					
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				24.0%	25.6%	**22.8%**	22.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										4	0	0	0	66.7%	0.0%
Quartile Summary for Focus Area Disparities										7	0	0	0	50.0%	0.0%

Washington County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				147.7	155.7	189.9	179.0	**204.6**	Above Benchmark						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				488.2	523.8	408.5	397.3	**429.1**	Worse	X					
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				2.0	1.3	2.2	3.2	**4.3**	Less than 10						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				64.4	64.9	29.4	21.3	**33.0**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	1	0	1	57.1%	25.0%
Other Indicators															
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				14.4*	N/A	**6.5**	7.4	N/A	Less than 10						
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10						
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10						
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				17.6	N/A	**17.4**	17.0	N/A	Worse	X					
5. Rate of Violent Crimes per 100,000 Population, 2017				124.8	171.8	**214.9**	355.6	N/A	Much Worse						

6. Rate of Property Crimes per 100,000 Population, 2017				690.5	1,481.8	**1,479.5**	1,466.1	N/A	Meets Benchmark							
7. Rate of Total Crimes per 100,000 Population, 2017				815.4	1,427.1	**1,694.4**	1,821.7	N/A	Meets Benchmark							
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10							
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				0.0*	N/A	**8.8**	6.3	N/A	Less than 10							
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				0.0*	N/A	**7.7**	5.5	N/A	Less than 10							
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	54	45	37	167.1	N/A	**167.3**	133.8	N/A	Meets Benchmark							
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	9	10	6	30.7	17.9	**18.5**	17.3	N/A	Worse	X						
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				1,695.9	2,162.0	**2,022.7**	1,558.5	N/A	Meets Benchmark							
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				266.2	364.7	**214.2**	141.6	N/A	Worse	X						
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				4.9	7.3	**7.1**	5.0	N/A	Meets Benchmark							
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				7.3	N/A	**8.6**	8.3	N/A	Meets Benchmark							
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				66.5	61.8	**68.3**	63.3	N/A	Meets Benchmark							
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10							
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				177.2	198.0	**239.3**	227.9	N/A	Meets Benchmark							
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				7.3	N/A	**7.1**	7.2	N/A	Worse	X						
Quartile Summary for Other Indicators										4	0	0	0	20.0%	0.0%	
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										6	1	0	1	29.6%	12.5%	

Washington County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				0.0%	0.0%	61.6%	35.6%	**32.0%**	Less than 10						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				19.6%	19.0%	22.9%	45.7%	**49.2%**	Worse	X					
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015.				4.4%	6.0%	3.9%	2.3%	**2.2%**	Worse	X					
4. Percentage of Adults Experiencing Food Insecurity '13/14				20.1%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				32.2%	29.9%	**30.9%**	35.5%	N/A	Worse	X					
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										3	0	0	0	50.0%	0.0%
Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				26.4%	26.9%	46.6%	70.8%	**78.5%**	Worse	X					
Quartile Summary for Focus Area Water Quality										1	0	0	0	100.0%	0.0%

Washington County
Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2013 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				40.2%	N/A	**27.4%**	25.5%	23.2%	Worse	X					
2. Percentage of Public School Children Who are Obese, '14 - 16				21.1%	N/A	17.3%	N/A	**16.7%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%
Other Indicators															
1. Percentage of Total Students Overweight, '16-18				18.8%	17.5%	**16.5%**	N/A	N/A	Worse	X					
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				18.9%	17.0%	**15.7%**	N/A	N/A	Worse	X					
3. Percentage of Elementary Student Obese, '16-18				18.4%	18.3%	**16.0%**	N/A	N/A	Worse	X					
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				19.1%	18.1%	**17.4%**	N/A	N/A	Worse	X					
5. Percentage of Middle and High School Students Obese, '16-18				25.3%	23.6%	**18.8%**	N/A	N/A	Worse	X					
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				17.8%	15.9%	**15.2%**	13.9%	N/A	Worse	X					
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				71.3%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				75.2%	73.9%	**74.6%**	73.7%	N/A	Meets/Better						

9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse	X						
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				78.7%	79.7%	**84.8%**	84.2%	N/A	Worse	X						
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				35.7%	36.0%	**33.0%**	31.7%	N/A	Worse	X						
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	195	149	169	275.2	295.6	**295.7**	272.2	N/A	Meets Better							
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	34	23	36	118.1	111.7	**101.0**	102.4	N/A	Worse	X						
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	108	91	92	156.1	165.4	**169.6**	153.2	N/A	Meets Better							
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				154.9	148.7	**1539.0**	149.9	N/A	Meets Better							
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	161	108	130	214.1	233.2	**236.5**	220.7	N/A	Meets Better							
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	27	19	31	97.8	95.9	**82.8**	83.4	N/A	Worse	X						
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	91	63	72	121.2	134.0	**140.7**	131.0	N/A	Meets Better							
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				104.5	103.1	**104.9**	100.3	N/A	Meets Better							
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	108	65	78	134.7	154.9	**162.7**	168.7	N/A	Meets Better							

21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	17	14	19	63.5	68.0	**60.5**	66.4	N/A	Worse	X						
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	59	41	46	78.3	91.1	**101.3**	105.0	N/A	Meets Better							
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				42.4	38.6	**35.4**	35.0	N/A	Worse	X						
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	8	7	10	13.4	17.6	**24.4**	16.5	N/A	Meets Better							
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	0	3	5.1*	4.8	**3.3**	2.5	N/A	Less than 10							
Failure Pretransport Deaths per 100,000 Population, '14-16	5	5	6	8.6	10.9	**14.5**	9.4	N/A	Meets Better							
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				23.9	24.2	**25.6**	24.8	N/A	Meets Better							
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	22	24	32	41.8	40.2	**38.1**	31.3	N/A	Worse	X						
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				27.2	23.8	**26.9**	25.4	N/A	Worse	X						
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				5.8	2.7	**9.4**	9.7	N/A	Meets Better							
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	22	22	17	32.7	29.5	**19.8**	20.3	N/A	Worse	X						
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				15.4	14.5	**15.4**	17.5	N/A	Meets Better							
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				265.4	246.1	**237.2**	248.1	N/A	Worse	X						
Quartile Summary for Other Indicators										18	0	0	0	54.5%	0.0%	

Quartile Summary for Focus Area Reduce Obesity in Children and Adults		19	1	0	0	57.1%	0.0%

Washington County
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	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				69.0%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				26.4	40.3	42.0	77.0	**75.1**	Meets Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				46.7	65.5	105.8	186.4	**196.5**	Meets Better						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				7.3*	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				5.2	5.0	4.1	4.0	**4.86**	Worse	X					
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				17.5	24.9	14.8	13.9	**14.0**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	50.0%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	161	134	106	33.8	52.4	**47.4**	77.3	N/A	Meets Better						
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	18	12	10	12.6	0.0	**19.1**	35.0	N/A	Meets Better						
3. Rate of All Cancer Cases per 100,000 Population, '13-15	379	398	419	638.0	683.8	**629.8**	564.4	N/A	Worse	X					

4. Rate of all Cancer Deaths per 100,000 Population, '13-15	149	130	134	220.3	227.3	**198.7**	176.2	N/A	Worse	X						
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	36	54	49	153.8	173.3	**175.9**	158.6	N/A	Much Better							
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	13	16	18	52.0	N/A	**53.1**	50.6	N/A	Much Better							
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	23.2	N/A	**26.1**	24.6	N/A	Much Better							
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.6%	81.4%	**79.2%**	79.7%	N/A	Worse	X						
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	10.0*	N/A	**7.6**	8.5	N/A	Less than 10							
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**2.3**	2.7	N/A	Less than 10							
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				87.8%	86.0%	**83.5%**	82.2%	N/A	Much Better							
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	15.5	N/A	**16.0**	14.8	N/A	Much Better							
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	12.2	N/A	**10.4**	9.1	N/A	Less than 10							
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	36	38	32	56.5	55.0	**48.5**	45.7	N/A	Worse	X						
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	14	8	13	18.7	18.9	**16.7**	15.6	N/A	Worse	X						
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				69.0%	73.6%	**68.5%**	69.7%	N/A	Much Better							

17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	20.6	N/A	**17.7**	17.3	N/A	Worse	X						
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	39	43	47	132.8	140.4	**151.7**	141.2	N/A	Much/Better							
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	8	9	17	35.0	30.0	**26.8**	25.2	N/A	Worse	X						
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10							
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	5,102	5,281	5,383	28.4%	25.7%	**28.3%**	28.0%	N/A	Much/Better							
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				66.5%	64.0%	**70.0%**	68.5%	N/A	Worse	X						
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15				N/A	N/A	**4.2**	4.5	N/A	Less than 10							
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	N/A	N/A	N/A	17.1	18.9	**14.7**	12.9	N/A	Worse	X						
Quartile Summary for Other Indicators										9	0	0	0	37.5%	0.0%	
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										12	0	0	0	40.0%	0.0%	

Washington County Revised:
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	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				13.2%	9.8%	10.5%	10.3%	**10.2%**	Worse	X					
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				0.69+	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				0.90	N/A	1.10	1.06	**1.00**	Meets Better						
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*%	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				49.9%	63.0%	50.9%	46.3%	**48.1%**	Meets Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				93.0%	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.82	N/A	0.68	0.59	**0.66**	Meets Better						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	7	1	11	1.1%	3.9%	**1.5%**	1.5%	N/A	Meets Better						

2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	41	56	53	8.8%	7.5%	7.4%	7.3%	N/A	Worse	X						
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	5	2	11	1.1%	1.2%	1.3%	1.4%	N/A	Much Better							
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	2	2	7	0.7%	0.9%	1.0%	1.0%	N/A	Much Better							
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	36	37	48	7.1%	6.7*%	7.6%	7.9%	N/A	Much Better							
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	29	27	31	5.3%	5.1*%	5.7%	6.0%	N/A	Much Better							
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	12.9%	12.2%	N/A	Less than 10							
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				2.2*%	N/A	7.5%	7.7%	N/A	Less than 10							
9. Infant Mortality Rate per 1,000 Live Births, '14-16	2	1	4	4.1*	5.7*	5.0	4.5	N/A	Less than 10							
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	2	2	2	3.5*	3.5*	5.3	5.1	N/A	Less than 10							
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	392	403	373	69.8%	75.4%	77.0%	75.2%	N/A	Worse	X						
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	68.5%	64.5%	N/A	Less than 10							
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				48.8%	N/A	71.1%	76.7%	N/A	Less than 10							
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	7	11	9	1.6%	1.1%	0.9%	0.7%	N/A	Worse	X						
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				136.0	0.0	0.0	104.8	N/A	Worse	X						
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				20.7%	N/A	30.7%	40.3%	N/A	Worse	X						

17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	372	390	364	78.6%	79.5%	82.9%	87.3%	N/A	Worse	X						
Quartile Summary for Other Indicators										6	0	0	0	35.3%	0.0%	
Quartile Summary for Focus Area Maternal and Infant Health										7	0	0	0	24.1%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				22.5%	23.2%	22.5%	19.8%	17.0%	Worse	X					
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				18.0	11.1	9.9	13.3	25.6	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	4.40	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	4.10	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				39.1%	32.9%	24.9%	22.6%	23.8%	Worse	X					
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	1.90	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	1.43	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.41	N/A	1.96	1.71	1.54	Meets/Better						
9. Percentage of Women Ages 18-64 with Health Insurance, 2016				95.1%	N/A	N/A	93.1%	100.0%	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	33.3%	0.0%
Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	585	584	542	56.7	53.2	57.2	58.5	N/A	Meets/Better						

2. Percent Multiple Births of Total Births, '14-16	22	24	24	4.1%	3.5%	**4.0%**	3.7%	N/A	Worse	X						
3. Percent C-Sections to Total Births, '14-16	174	194	193	32.8%	34.1%	**34.2%**	33.5%	N/A	Meets/Better							
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	703	744	706	71.3	64.5	**72.8**	83.8	N/A	Meets/Better							
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	1	0.4*	0.2*	**0.2**	0.2	N/A	Less than 10							
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	1	0.4*	0.3*	**0.4**	0.6	N/A	Less than 10							
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	18	20	19	17.7	12.5	**11.0**	15.1	N/A	Worse	X						
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	39	41	33	23.1	19.3	**13.2**	14.6	N/A	Worse	X						
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	58	63	55	36.0	28.1	**22.3**	29.8	N/A	Worse	X						
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	27	31	23	48.6	36.3*	**22.9**	25.6	N/A	Worse	X						
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	40	43	36	71.3	50.4	**37.5**	50.1	N/A	Worse	X						
12. Percent Total Births to Women Ages 35 Plus, '14-16	53	55	65	10.1%	11.7%	**20.2%**	22.1%	N/A	Meets/Better							
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16	19	22	20	539.8	434.5	**652.3**	990.8	N/A	Meets/Better							
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	90	144	138	217.4	181.4	**231.6**	370.9	N/A	Meets/Better							
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	23	26	17	5.0%	4.9%	**4.1%**	4.7%	N/A	Worse	X						
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	116	100	87	23.0%	22.3%	**26.3%**	26.6%	N/A	Meets/Better							

17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	142	142	134	31.7%	33.3%	**28.0%**	24.2%	N/A	Worse	X						
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	207	197	20	51.2%	52.4%	**47.1%**	41.7%	N/A	Worse	X						
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	26	30	27	6.9%	7.2%	**5.7%**	5.5%	N/A	Worse	X						
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	69	50	46	13.6%	12.9%	**9.1%**	7.1%	N/A	Worse	X						
Quartile Summary for Other Indicators										11	0	0	0	55.0%	0.0%	
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 15 Months with Government Insurance with Recommended Well Visits, 2016				88.0%	89.8%	82.8%	80.1%	**91.3%**	Worse	X					
2. Percentage of Children Ages 3 6 Years with Government Insurance with Recommended Well Visits, 2016				83.4%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				69.5%	69.5%	66.5%	68.1%	**67.1%**	Meets Benchmark						
4. Percentage of Children Ages 0 19 with Health Insurance, 2016				97.5%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	75.0%	0.0%
Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0	0	2	27.2*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	1	0	0	10.0*	9.0	**9.7**	10.0	N/A	Worse	X					

3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	12	18.9*	15.5	**11.5**	11.4	N/A	Less than 10
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	1	0	2	14.5*	12.3	**10.6**	10.7	N/A	Less than 10
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	1	1	3	46.1*	36.7	**32.6**	31.1	N/A	Less than 10
6. Rate of Asthma Hospitalizations Children Ages 0 4 per 10,000 Population Children, 2016				26.7*	N/A	**27.4**	43.5	N/A	Less than 10
7. Rate of Asthma Hospitalizations Children Ages 5 14 per 10,000 Population Children, 2016				N/A	N/A	**9.5**	18.7	N/A	Less than 10
8. Rate of Asthma Hospitalizations Children Ages 0 17 per 10,000 Population Children, 2016				10.9	N/A	**12.9**	23.5	N/A	Less than 10
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**8.1**	10.6	N/A	Less than 10
10. Rate of Otitis Media Hospitalizations Children Ages 0 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	2.2	N/A	Less than 10
11. Rate of Pneumonia Hospitalizations Children Ages 0 4 per 10,000 Population Children, 2016				33.4	N/A	**24.4**	30.9	N/A	Less than 10
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				46.7	65.5	**105.8**	186.4	196.5	Meets Target
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				0.2*%	0.7%	**1.2%**	1.9%	N/A	Less than 10
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				77.9%	77.5%	**71.7%**	74.8%	N/A	Meets Target
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				67.2%	63.7%	**55.9%**	62.8%	N/A	Meets Target

16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	28	14	11	20.6	11.4	**8.3**	4.3	N/A	Worse	X					
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				28.8	N/A	**18.1**	18.9	N/A	Less than 10						
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				31.9	N/A	**23.1**	23.1	N/A	Worse	X					
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				34.5	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	3,271	3,472	3,441	53.9%	48.0%	**48.0%**	47.5%	N/A	Meets/Better						
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				43.6%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				17.2%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				81.3%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				80.4%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				61.2%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				213.7	164.1	**119.7**	90.0	N/A	Worse	X					
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16				96.4%	85.7%	**85.0%**	85.3%	N/A	Worse	X					
Quartile Summary for Other Indicators										5	0	0	0	17.2%	0.0%
Quartile Summary for Focus Area Child Health										8	0	0	0	24.2%	0.0%

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	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4			
Focus Area: Human Immunodeficiency Virus (HIV)																
Prevention Agenda Indicators																
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				1.6*	N/A	**6.9**	16.0	16.1	Less than 10							0.00
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				N/A	N/A	**20.1**	35.2	46.8	Less than 10							0.00
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
1. Rate of AIDS Cases per 100,000 Population, '14-16	s	s	s	N/A	N/A	**3.3**	7.7	N/A	Less than 10							0.00
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	1	0	0.5*	N/A	**1.1**	3.0	N/A	Less than 10							0.00
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4			
Focus Area: Sexually Transmitted Disease (STDs)																
Prevention Agenda Indicators																
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10							0.00
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10							0.00
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				##########	60.6	197.1	206.2	**183.4**	Less than 10							0.00

4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016			###########	48.2	230.0	452.5	**199.5**	Less than 10							0.00
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016			1151.4	1170.1	1351.6	1620.7	**1458.0**	[illegible]							0.00
Quartile Summary for Prevention Agenda Indicators									0	0	0	0	0.0%	0.0%	
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	2	0	1.1*	2.52*	**7.9**	25.1	N/A	Less than 10							0.00
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	11	4	11	13.9	0.0	**0.0**	111.8	N/A	[illegible]	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!
3. Rate of Gonorrhea Ages 15 19 Cases per 100,000 Population Ages 15-19, '14-16	1	1	4	55.3*	45.8*	**209.9**	305.8	N/A	Less than 10							0.00
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	36	31	32	266.2	352.5	**569.5**	857.7	N/A	[illegible]							0.00
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	8	6	7	352.3	403.1	**607.9**	922.5	N/A	[illegible]							0.00
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	16	12	14	634.4	779.1	**1,199.7**	1,638.0	N/A	[illegible]							0.00
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	102	112	114	1,086.2	1,188.4	**1,300.3**	1,577.4	N/A	[illegible]							0.00
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	37	34	24	1,944.7	2,131.7	**2,300.5**	3,147.6	N/A	[illegible]							0.00
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	44	47	55	3,032.8	2,717.9	**2,833.9**	3,424.6	N/A	[illegible]	X						0.07
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016			N/A	N/A	**1.9**	2.5	N/A	Less than 10							0.00
Quartile Summary for Other Indicators									1	0	0	0	10.0%	0.0%	

Quartile Summary for Sexually Transmitted Diseases															
									1	0	0	0	6.7%	0.0%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4			
Focus Area: Vaccine Preventable Disease																
Prevention Agenda Indicators																
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				76.2%	73.9%	64.0%	N/A	**80.0%**	Worse	X						0.05
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				42.9%	42.6%	41.7%	N/A	**50.0%**	Meets/Better							0.00
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				55.8%	N/A	59.6%	59.5%	**70.0%**	Worse	X						0.20
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%	
Other Indicators																
1. Rate of Pertussis Cases per 100,000 Population, '13-15	2	0	0	1.1*	11.7	**5.9**	5.1	N/A	Less than 10							0.00
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				82.9	93.3	**93.7**	87.3	N/A	Meets/Better							0.00
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				75.6%	75.0%	**73.8%**	69.3%	N/A	Meets/Better							0.00
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09	**0.70**	1.08	N/A	Less than 10							0.00
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	1	0	0.5*	0.09*	**0.1***	0.1	N/A	Less than 10							0.00
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	0	1	0.5*	2.0	**1.7**	1.5	N/A	Less than 10							0.00
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Focus Area Vaccine Preventable Diseases										2	0	0	0	22.2%	0.0%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to	Quartile Ranking				Quartile	Severity
							New York	2018 Prevention							

	One	Two	Three	Years	ARHN	Upstate NY	State	Agenda	Benchmark	Q1	Q2	Q3	Q4	Score	Score	
Focus Area: Healthcare Associated Infections																
Prevention Agenda Indicators																
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				N/A	5.6	N/A	5.2	**5.94**	Less than 10							0.00
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				N/A	53.8	N/A	29.2	**2.05**	Less than 10							0.00
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%	

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	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				21.7%	N/A	19.1%	18.3%	**18.4%**	Worse	X					
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				13.1%	N/A	11.2%	10.7%	**10.1%**	Worse	X					
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				11.2	N/A	9.6	8.0	**5.9**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	100.0%	0.0%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				9.2*	10.7	**6.1**	5.0	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				7.6	N/A	**4.1**	3.5	N/A	Worse	X					
3. Rate of Self-inflicted Hospitalizations for Ages 15 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				11.3	13.8	**7.4**	8.0	N/A	Worse	X					
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				4.0	1.5	**3.3**	3.0	N/A	Worse	X					

7. Rate of Alcohol-Related Crashes per 100,000, 2017				71.4	69.1	**53.20**	38.0	N/A	Worse	X						
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				37.3	28.8	**10.5**	19.4	N/A	Worse	X						
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	62	95	99	13.6	14.6	**20.3**	24.0	N/A	Meets/Better							
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				630.4	1,279.4	**642.2**	682.2	N/A	Meets/Better							
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				371.2	819.5	**620.5**	689.7	N/A	Meets/Better							
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				45.4	141.7	**170.3**	311.4	N/A	Meets/Better							
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				0.0	15.6	**20.0**	18.9	N/A	Less than 10							
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				0.0	21.7	**20.0**	25.7	N/A	Less than 10							

15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015		0.0	N/A	5.7	7.6	N/A	Less than 10						
Quartile Summary for Other Indicators								5	0	0	0	33.3%	0.0%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders								8	0	0	0	44.4%	0.0%

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	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				22.3%	N/A	16.2%	14.2%	**12.3%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	100.0%	0.0%
Other Indicators															
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	39	56	51	78.3	72.8	**45.4**	34.8	N/A	Worse	X					
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				40.3	31.2	**28.0**	30.6	N/A	Worse	X					
3. Rate of Asthma Deaths per 100,000 Population, '14-16	1	3	0	2.1*	1.1*	**1.1**	1.5	N/A	Less than 10						
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				6.6	N/A	**6.3**	10.8	N/A	Worse	X					
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				N/A	N/A	**4.5**	5.6	N/A	Less than 10						
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				7.5	N/A	**5.1**	9.2	N/A	Less than 10						
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				6.2*	N/A	**4.4**	8.9	N/A	Less than 10						

8. Percentage of Adults with Asthma, '13-14				9.3%	12.0%	**10.1%**	9.5%	N/A	Many Better						
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	46	33	47	67.2	67.4	**53.0**	43.5	N/A	Worse	X					
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	59	63	70	102.4	112.2	**84.3**	69.7	N/A	Worse	X					
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				86.4	555.8	**101.3**	107.8	N/A	Many Better						
12. Percentage of Vendors with Sales to Minors Violations, '15-16				0.00	5.30	**3.90**	4.70	N/A	Many Better						
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Many Better						
Quartile Summary for Other Indicators										5	0	0	0	38.5%	0.0%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										6	0	0	0	42.9%	0.0%

Appendix G:

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	Source
Focus Area: Outdoor Air Quality	
1. Number of Days with Unhealthy Ozone, 2015-2017	Prevention Agenda Dashboard
2. Number of Days with Unhealthy Particulate Matter, 2015-2017	Prevention Agenda Dashboard
Quartile Summary for Focus Area Outdoor Air Quality	

Focus Area: Built Environment	
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017	Prevention Agenda Dashboard
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016	Prevention Agenda Dashboard
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015	Prevention Agenda Dashboard
4. Percentage of Adults Experiencing Food Insecurity '13/14	NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults Experiencing Housing Insecurity, 2016	NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016	Prevention Agenda Dashboard
Quartile Summary for Focus Area Built Environment	

Focus Area: Water Quality	
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017	Prevention Agenda Dashboard
Quartile Summary for Focus Area Water Quality	

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		Source
Preventive Care and Management in Both Clinical and Community Settings		
Prevention Agenda Indicators		
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016	0.14	Prevention Agenda Dashboard
2. Rate of Asthma ED Visits per 10,000 Population, 2016	0.00	Prevention Agenda Dashboard
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016	0.00	Prevention Agenda Dashboard
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016	0.00	Prevention Agenda Dashboard
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016	0.07	Prevention Agenda Dashboard
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016	0.25	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators		
Other Indicators		
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	0.00	Asthma Summary Report
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	0.00	Asthma Dashboard-County Level
3. Rate of All Cancer Cases per 100,000 Population, '13-15	0.01	Community Health Indicator Reports
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	0.11	Community Health Indicator Reports
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14	0.01	NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14	0.00	NYS Expanded Behavioral Risk Factor Surveillance System
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	0.00	Community Health Indicator Reports
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	0.16	Community Health Indicator Reports
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	0.12	Community Health Indicator Reports
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines	0.00	NYS Expanded Behavioral Risk Factor Surveillance System
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	0.16	Community Health Indicator Reports
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	0.00	Community Health Indicator Reports
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	0.31	Community Health Indicator Reports
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	0.00	Community Health Indicator Reports
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	0.00	Community Health Indicator Reports
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14	0.03	NYS Expanded Behavioral Risk Factor Surveillance System
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15	0.00	Community Health Indicator Reports
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	0.16	Community Health Indicator Reports
Quartile Summary for Other Indicators		
Chronic Disease Preventive Care & Management		

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Focus Area: Injuries, Violence, and Occupational Health	
Prevention Agenda Indicators	
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016	0.00 Prevention Agenda Dashboard
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016	0.14 Prevention Agenda Dashboard
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016	0.00 Prevention Agenda Dashboard
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016	0.00 Prevention Agenda Dashboard
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016	0.00 Prevention Agenda Dashboard
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016	0.00 Prevention Agenda Dashboard
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016	0.95 Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators	
Other Indicators	
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016	0.00 Community Health Indicator Reports
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016	0.00 Community Health Indicator Reports
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016	0.00 Community Health Indicator Reports
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016	0.01 Community Health Indicator Reports
5. Rate of Violent Crimes per 100,000 Population, 2017	0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates
6. Rate of Property Crimes per 100,000 Population, 2017	0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates
7. Rate of Total Crimes per 100,000 Population, 2017	0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15	0.00 Community Health Indicator Reports
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016	0.00 Community Health Indicator Reports
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016	0.00 Community Health Indicator Reports
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	0.00 Community Health Indicator Reports
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	0.66 Community Health Indicator Reports
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017	0.00 NYS Traffic Safety Statistical Repository
14. Rate of Speed-Related Accidents per 100,000 Population, 2017	0.24 NYS Traffic Safety Statistical Repository
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017	0.00 NYS Traffic Safety Statistical Repository
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016	0.00 Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016	0.00 Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016	0.00 Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016	0.00 Community Health Indicator Reports
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016	0.03 Community Health Indicator Reports
Quartile Summary for Other Indicators	
Occupational Health	

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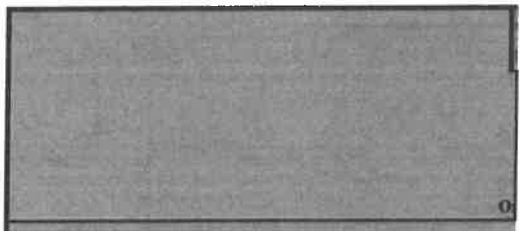
	Source
Focus Area: Human Immunodeficiency Virus (HIV)	
Prevention Agenda Indicators	
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016	Prevention Agenda Dashboard
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators	
Other Indicators	
1. Rate of AIDS Cases per 100,000 Population, '14-16	Community Health Indicator Reports
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	Community Health Indicator Reports
Quartile Summary for Other Indicators	
Virus (HIV)	

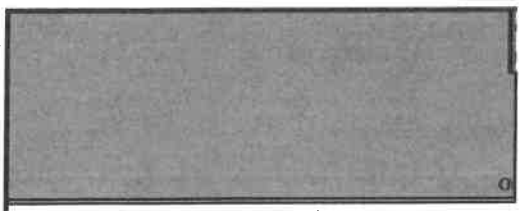
Focus Area: Sexually Transmitted Disease (STDs)	
Prevention Agenda Indicators	
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016	Prevention Agenda Dashboard
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016	Prevention Agenda Dashboard
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016	Prevention Agenda Dashboard
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016	Prevention Agenda Dashboard
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators	
Other Indicators	
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	Community Health Indicator Reports
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	Community Health Indicator Reports
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	Community Health Indicator Reports
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	Community Health Indicator Reports
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	Community Health Indicator Reports
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	Community Health Indicator Reports
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	Community Health Indicator Reports
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	Community Health Indicator Reports

9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	Community Health Indicator Reports
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016	Community Health Indicator Reports
Quartile Summary for Other Indicators	
Quartile Summary for Sexually Transmitted Diseases	



Focus Area: Vaccine Preventable Disease

Prevention Agenda Indicators	
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4; 2016	Prevention Agenda Dashboard
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016	Prevention Agenda Dashboard
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators	
Other Indicators	
1. Rate of Pertussis Cases per 100,000 Population, '13-15	Community Health Indicator Reports
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14	Community Health Indicator Reports
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14	NYS Expanded Behavioral Risk Factor Surveillance System
4. Rate of Mumps Cases per 100,000 Population, '13-15	Community Health Indicator Reports
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	Community Health Indicator Reports
6. Rate of H Influenza Cases per 100,000 Population, '13-15	Community Health Indicator Reports
Quartile Summary for Other Indicators	
Quartile Summary for Focus Area Vaccine Preventable Diseases	



Focus Area: Healthcare Associated Infections

Prevention Agenda Indicators	
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017	NYS Department of Health Hospital Report on Hospital Acquired Infections
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017	NYS Department of Health Hospital Report on Hospital Acquired Infections
Quartile Summary for Healthcare Associated Infections	

Washington County Revised: April 2019

		Source	Updated
Focus Area: Maternal and Infant Health			
Prevention Agenda Indicators			
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016	0.29	Prevention Agenda Dashboard	
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016	0.00	Prevention Agenda Dashboard	
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016	0.00	Prevention Agenda Dashboard	
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016	0.00	Prevention Agenda Dashboard	
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016	0.00	Prevention Agenda Dashboard	
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016	0.00	Prevention Agenda Dashboard	
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016	0.00	Prevention Agenda Dashboard	
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016	0.00	Prevention Agenda Dashboard	
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016	0.00	Prevention Agenda Dashboard	
Quartile Summary for Prevention Agenda Indicators			
Other Indicators			
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	0.00	Community Health Indicator Reports	
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	0.19	Community Health Indicator Reports	
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	0.00	Community Health Indicator Reports	
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	0.00	Community Health Indicator Reports	
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	0.00	Community Health Indicator Reports	
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	0.00	Community Health Indicator Reports	
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16	0.00	State and County Indicators for Tracking Publi	
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16	0.00	State and County Indicators for Tracking Publi	
9. Infant Mortality Rate per 1,000 Live Births, '14-16	0.00	Community Health Indicator Reports	
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	0.00	Community Health Indicator Reports	
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	0.09	Community Health Indicator Reports	
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16	0.00	State and County Indicators for Tracking Publi	
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16	0.00	State and County Indicators for Tracking Publi	

14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	0.78 Community Health Indicator Reports
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15	0.00 Community Health Indicator Reports
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16	0.33 Community Health Indicator Reports
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	0.05 Community Health Indicator Reports
Quartile Summary for Other Indicators	
Quartile Summary for Focus Area Maternal and Infant Health	

Focus Area: Preconception and Reproductive Health

Prevention Agenda Indicators

1. Percent of Births within 24 months of Previous Pregnancy, 2016	0.32 Prevention Agenda Dashboard
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016	0.00 Prevention Agenda Dashboard
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016	0.00 Prevention Agenda Dashboard
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016	0.00 Prevention Agenda Dashboard
5. Percent of Unintended Pregnancies among Total Births, 2016	0.64 Prevention Agenda Dashboard
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016	0.00 Prevention Agenda Dashboard
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016	0.00 Prevention Agenda Dashboard
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016	0.00 Prevention Agenda Dashboard
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016	0.05 Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators	

Other Indicators

1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	0.00 Community Health Indicator Reports
2. Percent Multiple Births of Total Births, '14-16	0.03 Community Health Indicator Reports
3. Percent C-Sections to Total Births, '14-16	0.00 Community Health Indicator Reports
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	0.00 Community Health Indicator Reports
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0.00 Community Health Indicator Reports
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0.00 Community Health Indicator Reports
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	0.61 Community Health Indicator Reports
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	0.75 Community Health Indicator Reports
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	0.61 Community Health Indicator Reports
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	1.12 Community Health Indicator Reports
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	0.90 Community Health Indicator Reports
12. Percent Total Births to Women Ages 35 Plus, '14-16	0.00 Community Health Indicator Reports
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16	0.00 Community Health Indicator Reports
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	0.00 Community Health Indicator Reports
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	0.22 Community Health Indicator Reports

16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	0.00	Community Health Indicator Reports
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	0.13	Community Health Indicator Reports
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	0.09	Community Health Indicator Reports
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	0.20	Community Health Indicator Reports
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	0.49	Community Health Indicator Reports
Quartile Summary for Other Indicators		
Reproductive Health		

Focus Area: Child Health		
Prevention Agenda Indicators		
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016	0.04	Prevention Agenda Dashboard
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016	0.09	Prevention Agenda Dashboard
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016	0.00	Prevention Agenda Dashboard
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016	0.03	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators		
Other Indicators		
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0.00	Community Health Indicator Reports
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	#VALUE!	Community Health Indicator Reports
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0.00	Community Health Indicator Reports
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	0.00	Community Health Indicator Reports
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	0.00	Community Health Indicator Reports
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016	0.00	Asthma Dashboard-County Level
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013	0.00	Community Health Indicator Reports
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013	0.00	Community Health Indicator Reports
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013	0.00	Community Health Indicator Reports
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	1.48	Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016	0.00	Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016	0.38	Community Health Indicator Reports

20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016	0.00	Asthma Summary Report
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	0.00	Community Health Indicator Reports
22. Percentage of 3rd Graders with Dental Caries, '09 - 11	0.00	Community Health Indicator Reports
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11	0.00	Community Health Indicator Reports
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11	0.00	Community Health Indicator Reports
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11	0.00	Community Health Indicator Reports
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11	0.00	Community Health Indicator Reports
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016	0.79	Community Health Indicator Reports
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16	0.13	Community Health Indicator Reports
Quartile Summary for Other Indicators		
Quartile Summary for Focus Area Child Health		

Washington County Revised: April 2019

		Source
Focus Area: Disparities		
Prevention Agenda Indicators		
1. Percentage of Overall Premature Deaths (before age 65 years), 2016	0.09	Prevention Agenda Dashboard
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	0.00	Prevention Agenda Dashboard
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	0.00	Prevention Agenda Dashboard
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016	0.26	Prevention Agenda Dashboard
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016	0.00	Prevention Agenda Dashboard
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016	0.00	Prevention Agenda Dashboard
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016	0.06	Prevention Agenda Dashboard
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016	0.00	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators		
Other Disparity Indicators		
1. Rate of Total Deaths per 100,000 Population, 2014-2016	-0.12	Community Health Indicator Reports
2. Rate of Emergency Department Visits per 10,000 Population, 2016	0.00	Community Health Indicator Reports
3. Rate of Total Hospitalizations per 10,000 Population, 2016	0.00	Community Health Indicator Reports
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016	0.09	NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016	0.32	NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Adults (18 and Older) Living with a Disability, 2016	0.05	NYS Expanded Behavioral Risk Factor Surveillance System
Quartile Summary for Other Indicators		
Quartile Summary for Focus Area Disparities		

Washington County Revised: April 2019

		Source	Updated
Focus Area: Reduce Obesity in Children and Adults			
Prevention Agenda Indicators			
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016	0.73	Prevention Agenda Dashboard	
2. Percentage of Public School Children Who are Obese, '14 - 16	0.26	Prevention Agenda Dashboard	
Quartile Summary for Prevention Agenda Indicators			
Other Indicators			
1. Percentage of Total Students Overweight, '16-18	0.14	Student Weight Status Category Reporting System (SWSCRS) Data	
2. Percentage of Elementary Students Overweight, Not Obese, '16-18	0.20	Student Weight Status Category Reporting System (SWSCRS) Data	
3. Percentage of Elementary Student Obese, '16-18	0.15	Student Weight Status Category Reporting System (SWSCRS) Data	
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18	0.10	Student Weight Status Category Reporting System (SWSCRS) Data	
5. Percentage of Middle and High School Students Obese, '16-18	0.35	Student Weight Status Category Reporting System (SWSCRS) Data	
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16	-0.17	Community Health Indicator Reports	
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016	0.12	NYS Expanded Behavioral Risk Factor Surveillance System	
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016	0.00	NYS Expanded Behavioral Risk Factor Surveillance System	
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014	0.68	USDA Economic Research Service Fitness Facilities Data	
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14	0.07	NYS Expanded Behavioral Risk Factor Surveillance System	
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14	0.08	NYS Expanded Behavioral Risk Factor Surveillance System	
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0.17	Community Health Indicator Reports	
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016	0.00	Community Health Indicator Reports	
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0.18	Community Health Indicator Reports	
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016	0.00	Community Health Indicator Reports	
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0.05	Community Health Indicator Reports	
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016	0.20	Community Health Indicator Reports	
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	0.00	Community Health Indicator Reports	
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports	
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016	0.00	Community Health Indicator Reports	
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	0.10	Community Health Indicator Reports	
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016	0.01	Community Health Indicator Reports	
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016	0.00	Community Health Indicator Reports	
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	0.65	Community Health Indicator Reports	
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016	0.00	Community Health Indicator Reports	
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016	0.12	Community Health Indicator Reports	
Quartile Summary for Other Indicators			
and Adults			

Washington County Revised: April 2019

Other Non-Prevention Agenda Indicators		Source
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0.00	Community Health Indicator Reports
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0.00	Community Health Indicator Reports
3. Rate of TB Cases per 100,000 Population, '14-16	0.00	Community Health Indicator Reports
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	0.00	Community Health Indicator Reports
5. Rate of Salmonella Cases per 100,000 Population, '14-16	0.03	Community Health Indicator Reports
6. Rate of Shigella Cases per 100,000 Population, '14-16	0.00	Community Health Indicator Reports
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	0.00	Community Health Indicator Reports
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015	0.97	Department of Health, Wadsworth Center
Quartile Summary for Non-Prevention Agenda Issues		

Washington County Revised: April 2019

		Source
Tobacco Use and Secondhand Smoke Exposure		
Prevention Agenda Indicators		
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016	0.81	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators		
Other Indicators		
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	0.72	Community Health Indicator Reports
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016	0.44	Community Health Indicator Reports
3. Rate of Asthma Deaths per 100,000 Population, '14-16	0.00	Community Health Indicator Reports
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016	0.05	Community Health Indicator Reports
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016	0.00	Community Health Indicator Reports
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016	0.00	Community Health Indicator Reports
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016	0.00	Community Health Indicator Reports
8. Percentage of Adults with Asthma, '13-14	0.00	NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	0.27	Community Health Indicator Reports
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	0.21	Community Health Indicator Reports
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16	0.00	NYS Department of Health Tobacco Enforcement Compliance Results
12. Percentage of Vendors with Sales to Minors Violations, '15-16	0.00	NYS Department of Health Tobacco Enforcement Compliance Results
13. Percentage of Vendors with Complaints, '15-16	0.00	NYS Department of Health Tobacco Enforcement Compliance Results
Quartile Summary for Other Indicators		
Death Related to Tobacco Use & Secondhand Smoke Exposure		

Washington County Revised: April 2019

		Source
Emtional, and Behavorial Disorders		
Prevention Agenda Indicators		
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016	0.18	Prevention Agenda Dashboard
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016	0.30	Prevention Agenda Dashboard
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16	0.90	Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators		
Other Indicators		
1. Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16	0.00	Community Health Indicator Reports
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016	0.85	Community Health Indicator Reports
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016	0.00	Community Health Indicator Reports
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16	0.53	Community Health Indicator Reports
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016	0.21	Community Health Indicator Reports
7. Rate of Alcohol-Related Crashes per 100,000, 2017	0.88	NYS Traffic Safety Statistical Repository
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017	2.55	NYS Traffic Safety Statistical Repository
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	0.00	Community Health Indicator Reports
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015	0.00	NYS Office of Mental Health, PCS Summary Report
Quartile Summary for Other Indicators		
Other Mental, Emotional, and Behavorial Disorders		

Appendix H

RESOURCES

Sources for Evidence Based Interventions

The Prevention Agenda https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

The Community Guide (Community Preventive Services Task Force) https://www.thecommunityguide.org/task-force-findings

County Health Rankings – What Works for Health http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

CDC 6/18 Initiative https://www.cdc.gov/sixeighteen/

CDC Health Impact in Five Years https://www.cdc.gov/policy/hst/hi5/index.html

CDC Community Health Improvement Navigator https://wwwn.cdc.gov/chidatabase

Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices https://www.samhsa.gov/nrepp?_sm_au_=iHVVZpZ0Q8L1rspF

Successful Interventions to Reduce Health Disparities https://www.cdc.gov/mmwr/ind2016_su.html

The Cochrane Database http://www.cochranelibrary.com/

Data resources:

New York State Prevention Agenda Tracking Indicator Dashboard

The New York State Prevention Agenda Dashboard is an interactive visual presentation of the most current Prevention Agenda tracking indicator data at state and county levels. It can be used to monitor progress toward meeting the Prevention Agenda 2018 objectives.

Sub-County Health Data Reports for County Health Rankings-Related Measures (2016)

These reports provide data for 11 health measures at sub-county levels, including sub-county populations (such as race/ethnicity, age group, Medicaid status, education level) and sub-county geographies (ZIP codes and minor civil divisions where data are available). These reports can be used to assess community health needs, to plan health interventions, and specifically to identify health disparities within counties.

Community Health Indicator Reports

This site links the previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI), with nearly 300 health-related indicators available. State and county trend data are available for most indicators. The top part of this site allows the user to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides access to individual county profiles of these health topic areas with direct links to county historical (trend) data.

County Health Indicators by Race/Ethnicity (CHIRE)

CHIRE provides selected public health indicators by race/ethnicity for New York State and counties. Data related to births, deaths, and hospitalizations are presented.

New York State 2017 Health Equity Reports

The New York State 2017 Health Equity Reports present data on health outcomes, demographics, and other community characteristics for select cities and towns with a 40% or greater non-White population throughout New York State. Each town or city specific report contains data associated with the priority areas of the Prevention Agenda, as well as social determinant indicators such as housing, educational attainment and insurance coverage.

U.S. Census Bureau

The U.S. Census Bureau webpage provides links by topic, geography or data system or survey to a vast array of information available from the U.S. Census.

US Census Bureau - American Fact Finder

The Census Bureau, through American Fact Finder, provides access to data from the Decennial Census, American Community Survey, Annual Population Estimates Program and other economic and business- related surveys. The Fact Finder data system allows a user to search for data by topic, geography (state, county, town, and city), race/ethnic groups and industrial codes.

Additional resources can be found at:
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm

Appendix I

Washington County Community Health Assessment Resident Survey

Survey Methodology:

Survey creation: The 2019 Washington County Community Health Assessment Resident Survey was drafted by public health administration based on historical identified data needs and the desire to include the general public in the priority setting process. Surveys from other regional health departments and nationally sourced community surveys were reviewed and assessed for useful knowledge, question validity, specificity and effectiveness.

Survey facilitation: Washington County Public Health staff deployed the surveys by two survey modalities, paper in person and online via Survey Monkey. The goal was to glean community input and information regarding health care needs and identified community level priorities. Stakeholders included young adults and adult residents of the towns and villages in Washington County.

Survey logistics: Survey modalities included in person paper surveys distributed at the Washington County Fair, the larges attended social event of the year in the County. It draws a large cross section of the population. The second modality was through Survey Monkey, participation was encouraged through wide spread advertisement on County social media sites, via distribution to other community based and county organizations that serve the public to engage their constituents and via clinics and home visits conducted by public health staff.

2019 Washington County Resident Community Health Survey

Thank you for taking the time to offer your input and ideas to the Health Department about your opinions and health concerns for **your** community.

Washington County Public Health will use the survey and other information to identify priority issues in our communities. **Your** input is very important in this decision making!

1. **Please rate the overall health of your community:**

□ Very healthy	□ Healthy	□ Somewhat healthy	□ Unhealthy	□ Very unhealthy

2. **What are the biggest Health Issues you see going on in your community? (pick 3)**

□ Access to medical care	□ Mental health issues
□ Aging issues (arthritis, hearing, vision loss)	□ Overweight/Obesity
□ Cancer	□ Physical inactivity
□ Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke)	□ Prenatal care/Maternal Infant Health
□ Dental health	□ Sexually transmitted infections (including HIV)
□ Falls	□ Substance abuse (drugs, alcohol)
□ Immunizations	□ Suicide
□ Infectious diseases (Hepatitis, flu, etc.)	□ Tobacco use/Vaping
□ Lung Diseases (asthma, COPD, etc.)	Other:_____

3. **What are the Social Issues you see as the greatest concerns in your community? (pick 3)**

□ Access to healthy food	□ Hunger / lack of food
□ Opportunities for those with physical limitations or disabilities	□ Safe streets (crosswalks, bike lanes, shoulders)
□ Bullying	□ Opportunities for physical activity
□ Child abuse/neglect	□ Safe areas to walk, play
□ Racism/discrimination	□ Crime /Incarceration rates (people in jail)
□ Domestic violence	□ Transportation
□ Elder abuse/neglect	□ Unemployment /low pay
□ Homelessness	Other:

4. **What Environmental Issues are of greatest concern to you? (pick 4)**

□ Air pollution	□ Drinking water quality
□ Exposure to tobacco smoke	□ Stream, river, lake water quality
□ Exposure to Vaping	□ Flooding /soil drainage
□ Agricultural run-off (manure)	□ Climate change
□ Safe food	□ Mosquitos, ticks
□ Lead paint hazards	□ Nuisance wildlife, stray animals
□ Home safety	□ School safety

2019 Washington County Resident Community Health Survey

Other:	

5. **When you imagine a strong, vibrant and healthy community, what do you think are the most important features? (pick 3)**

□ Senior housing	□ Good pay	□ Diverse population
□ Safe environments	□ Good healthcare services	□ Affordable housing
□ Wide range of Senior services	□ Parks and recreation resources	□ Friendly and walkable communities
□ Transportation	□ Good schools	□ Health food choices
□ Mental health services	□ Clean environments	□ Available jobs
□ Drug and alcohol services	□ Available childcare	
Other:		

6. **What do you feel are the biggest <u>Barriers</u> that keep people from getting the healthcare they need in your community? (pick 3).**

□ Could not pay	□ No access for people with disabilities
□ Do not have a doctor	□ No appointments available
□ Do not have childcare	□ Provider did not speak my language
□ Do not have insurance	□ Do not have transportation
□ Time limitations (long waits, limited office hours, time off difficult to get)	□ Provider does not accept insurance
□ Do not understand the health care system	□ People have difficulty meeting basic needs such as food and housing
Other:	□ None of the above

7. **Please tell us about yourself!**

Gender: □ Male □ Female

Age:

□ 17 years and under	□ 18-24 years	□ 25-44 years	□ 45-64 years	□ 65 years and over

How would you rate your own health?

□ Very healthy	□ Healthy	□ Somewhat healthy	□ Unhealthy	□ Very unhealthy

Have you gotten benefits from the following programs in the last 2 years? (check all that apply)

□ HEAP	□ SNAP	□ WIC
□ None of theses	□ Prefer not to answer	

What is the highest level of school you have completed?

□ 12th grade or less- in school now	□ 12th grade or less did not graduate
□ High school diploma/GED	□Some college tech school or trade school
□ Associates degree	□ Bachelor's degree

2019 Washington County Resident Community Health Survey

Washington County Public Health
Prevent. Promote. Protect.

□ Master's degree or higher	□ Prefer not to answer

Do you have a Health Care Provider (Doctor, Nurse Practitioner, Physician Assistant) that you see for routine health needs? □ Yes □ No

What town do you live in?

□ Argyle	□ Granville	□ Jackson	□
□ Cambridge	□ Greenwich	□ Putnam	□
□ Dresden	□ Hampton	□ Salem	□
□ Easton	□ Hartford	□ White Creek	□
□ Fort Ann	□ Hebron	□ Whitehall	□
□ Fort Edward	□ Hudson Falls	□ Other:	

What is <u>one thing</u> you can recommend to us to improve the health of your community?

Thank you for your valuable input, please submit your responses for a Thank you gift!

2019 Washington County Resident Community Health Survey

Q1. Please rate the overall health of your community:

Answer Choices	Responses	
Very healthy	0.00%	0
Healthy	10.53%	2
Somewhat healthy	57.89%	11
Unhealthy	26.32%	5
Very unhealthy	5.26%	1
	Answered	**19**
	Skipped	**1**

Q2. What are the biggest Health Issues you see going on in your community? (pick 3)

Answer Choices	Responses	
Access to medical care	25.00%	5
Aging issues (arthritis, hearing, vision loss)	5.00%	1
Cancer	15.00%	3
Chronic disease (diabetes, heart disease, high blood pressure, high c	35.00%	7
Dental health	15.00%	3
Falls	0.00%	0
Immunizations	0.00%	0
Infectious diseases (Hepatitis, flu, etc.)	5.00%	1
Lung Diseases (asthma, COPD, etc.)	10.00%	2
Mental health issues	35.00%	7
Overweight/Obesity	50.00%	10
Physical inactivity	35.00%	7
Prenatal care/Maternal Infant Health	5.00%	1
Sexually transmitted infections (including HIV)	0.00%	0
Substance abuse (drugs, alcohol)	75.00%	15
Suicide	0.00%	0
Tobacco use/Vaping	40.00%	8
Other (please specify)	5.00%	1
	Answered	**20**
	Skipped	**0**

Respondents	Response Date (please spe	Tags
1	Sep 06 2019 0	Pollution and pedestrian sa

Q3. What are the Social Issues you see as the greatest concerns in your community? (p

Answer Choices	Responses	
Access to healthy food	40.00%	8
Opportunities for those with physical limitations or disabilities	15.00%	3
Bullying	10.00%	2
Child abuse/neglect	25.00%	5
Racism/discrimination	5.00%	1
Domestic violence	20.00%	4
Elder abuse/neglect	10.00%	2

Homelessness	0.00%	0
Hunger / lack of food	15.00%	3
Safe streets (crosswalks, bike lanes, shoulders)	30.00%	6
Opportunities for physical activity	20.00%	4
Safe areas to walk, play	25.00%	5
Crime /Incarceration rates (people in jail)	20.00%	4
Transportation	35.00%	7
Unemployment /low pay	60.00%	12
Other (please specify)	15.00%	3
	Answered	**20**
	Skipped	**0**

Respondents	Response Date	Response (please spe	Tags
1	Sep 19 2019	1	High property taxes
2	Sep 06 2019	1	poverty
3	Sep 06 2019	0	Affordable housing

Q4. What Environmental Issues are of greatest concern to you? (pick 4)

Answer Choices	Responses	
Air pollution	20.00%	4
Exposure to tobacco smoke	35.00%	7
Exposure to Vaping	30.00%	6
Agricultural run-off (manure)	15.00%	3
Safe food	20.00%	4
Lead paint hazards	10.00%	2
Home safety	30.00%	6
Drinking water quality	40.00%	8
Stream, river, lake water quality	35.00%	7
Flooding /soil drainage	10.00%	2
Climate change	10.00%	2
Mosquitos, ticks	65.00%	13
Nuisance wildlife, stray animals	10.00%	2
School safety	45.00%	9
Other (please specify)	0.00%	0
	Answered	**20**
	Skipped	**0**

Q5. When you imagine a strong, vibrant and healthy community, what do you think are t

Answer Choices	Responses	
Senior housing	10.00%	2
Safe environments	55.00%	11
Wide range of Senior services	10.00%	2
Transportation	20.00%	4
Mental health services	35.00%	7
Drug and alcohol services	5.00%	1

Good pay	15.00%	3
Good healthcare services	35.00%	7
Parks and recreation resources	20.00%	4
Good schools	30.00%	6
Clean environments	20.00%	4
Available childcare	5.00%	1
Diverse population	0.00%	0
Affordable housing	15.00%	3
Friendly and walkable communities	35.00%	7
Health food choices	10.00%	2
Available jobs	20.00%	4
Other (please specify)	0.00%	0
	Answered	**20**
	Skipped	**0**

Q6. What do you feel are the biggest Barriers that keep people from getting the healthca

Answer Choices	Responses	
Could not pay	60.00%	12
Do not have a doctor	25.00%	5
Do not have childcare	0.00%	0
Do not have insurance	25.00%	5
Time limitations (long waits, limited office hours, time off difficult to ge	40.00%	8
Do not understand the health care system	25.00%	5
No access for people with disabilities	5.00%	1
No appointments available	15.00%	3
Provider did not speak my language	0.00%	0
Do not have transportation	45.00%	9
Provider does not accept insurance	15.00%	3
People have difficulty meeting basic needs such as food and housing	30.00%	6
None of the above	0.00%	0
Other (please specify)	20.00%	4
	Answered	**20**
	Skipped	**0**

Respondents	Response Date	Response (please spe	Tags
1	Oct 13 2019 0	Lack of local healthcare	
2	Sep 19 2019 1	lack of motivation	
3	Sep 06 2019 0	No Dental or oral surgery th	
4	Sep 06 2019 1	lack of understanding/low li	

Q7. Gender:

Answer Choices	Responses	
Male	5.26%	1
Female	94.74%	18
Other	0.00%	0

Answered		**19**
Skipped		**1**

Q8. Age:

Answer Choices	Responses	
17 years and under	0.00%	0
18-24 years	5.26%	1
25-44 years	47.37%	9
45-64 years	42.11%	8
65 years and over	5.26%	1
Answered		**19**
Skipped		**1**

Q9. How would you rate your own health?

Answer Choices	Responses	
Very healthy	10.53%	2
Healthy	42.11%	8
Somewhat healthy	42.11%	8
Unhealthy	5.26%	1
Very unhealthy	0.00%	0
Answered		**19**
Skipped		**1**

Q10. What town do you live in?

Answer Choices	Responses	
Argyle	15.79%	3
Cambridge	5.26%	1
Dresden	0.00%	0
Easton	0.00%	0
Fort Ann	15.79%	3
Fort Edward	10.53%	2
Granville	0.00%	0
Greenwich	5.26%	1
Hampton	0.00%	0
Hartford	0.00%	0
Hebron	5.26%	1
Hudson Falls	15.79%	3
Jackson	0.00%	0
Putnam	0.00%	0
Salem	10.53%	2
White Creek	0.00%	0
Whitehall	15.79%	3
Other (please specify)	0.00%	0
Answered		**19**
Skipped		**1**

Q11. Do you have a Health Care Provider (Doctor, Nurse Practitioner, Physician Assista

Answer Choices	Responses	
Yes	89.47%	17
No	10.53%	2
	Answered	**19**
	Skipped	**1**

Q12. Have you gotten benefits from the following programs in the last 2 years? (check a

Answer Choices	Responses	
HEAP	0.00%	0
SNAP	5.26%	1
WIC	10.53%	2
None of these	84.21%	16
	Answered	**19**
	Skipped	**1**

Q13. What is the highest level of school you have completed?

Answer Choices	Responses	
12th grade or less- in school now	0.00%	0
High school diploma/GED	10.53%	2
Associates degree	21.05%	4
Master's degree or higher	15.79%	3
12th grade or less did not graduate	0.00%	0
Some college tech school or trade school	26.32%	5
Bachelor's degree	26.32%	5
Prefer not to answer	0.00%	0
	Answered	**19**
	Skipped	**1**

Q14. What is one thing you can recommend to us to improve the health of your commur

Answered	**11**
Skipped	**9**

Respondents	Response Date	Responses	Tags
1	Oct 13 2019 0	More opportunities for healt	
2	Oct 07 2019 0	Better access for transporta	
3	Sep 25 2019 1	Walking trails would be grea	
4	Sep 20 2019 0	Sponsor community fitness	
5	Sep 19 2019 1	Encourage physical activity	
6	Sep 13 2019 0	The village of Whitehall nee	
7	Sep 09 2019 0	Volunteers for EMS and Fir	
8	Sep 06 2019 0	Make the traffic slow down	
9	Sep 06 2019 1	Unsure	
10	Aug 31 2019 1	Better healthcare	

2019 Washington County Resident Community Health Survey

Qualitative Responses

What is the one thing you can recommend to us to improve the health of your community?

- Focus on Senior programs
- Housing
- Environmental safety
- Mental health access
- Kids need more discipline
- More parent classes
- Get information out to people who don't know what is available to them. People just don't know and are uneducated
- Attention to the needs of the elderly they go without basic necessities because of low income and transportation. Some have just enough money, don't qualify for Medicaid or other services but no money to afford RX
- Free vaccines
- Water
- Mental health services substance abuse
- Care coordination with people
- Tobacco free grounds
- Better healthcare facilities
- Transportation
- Lyme pandemic
- Climate change
- Mental health not provided in our county to a great enough extent literacy not addressed in relation to the incarcerated population. Working with those who are incarcerated and help them with addiction etc. will help benefit our county.
- Medicare for all
- Access to care with specialists, increase food stamp benefits to decrease
- Get kids and families more active in the community
- More community focused events, "town clean ups "etc....
- A lot comes down to affordability, mental health for children is hard to get
- Mental health support
- Eliminate drugs
- Easy access
- Five people filled this out
- More town wide opportunities for physical activity
- Lyme awareness
- More available doctors and times for seeing patients

- More cheap housing for the elderly
- More bike trails and walking paths
- More staff at health centers, better transportation (more options)
- Nutrition education
- More information about available resources
- Drink and eat more dairy products
- New government
- Dental care thank you for helping me when I was sick
- More usable transportation
- No more bullying in schools
- Treat roadsides for mosquitos and tick population
- Bring youth commission back (Easton), transportation for the elderly
- Safer places to let children play to give parents a peace of mind
- Senior home visits
- Better opportunities in schooling
- Drug use
- Mental health system need revamping
- Problem with ticks
- New living in Washington County coming from Saratoga more available senior citizen especially senior dining program
- Free exercise community programs/ hiking trails, etc. to get people interested in physical activity
- Easier access to medical facilities
- More nice people helping other kids that respect other. Less kids abuse, homeless older people that people leave behind or abuse (17yo)
- Control ticks
- Safer streets
- Greater access to health care
- Helping those who can't afford insurance. We have to go through Saratoga Hospital for financial assistance
- More affordable Health insurance
- Nothing at this time you are doing great.
- Lower health insurance
- More home health aides for Seniors who can't afford it and more welfare checks an services on the families who only want the money from parents or the person they take care of
- Safety of water PFOAs
- n/a
- educate the people
- education of health issues created by poor choices by individuals including diet and exposure

- get doctors
- curb drug usage
- vibrant downtown, empty store fronts
- getting more Doctors in here
- community garden
- more information keep informed
- social activities for adults and seniors
- parks and recreation areas
- safer shoulders for walking in rural areas reasonable road speeds
- more DOC
- lower cost of insurance so people can keep healthy lower prices of healthy foods
- more education re: healthy food option available in our community
- domestic violence support groups minimal
- access to information
- closer hospital
- stop smoking and drinking
- access to medical care
- Lyme
- more bus runs to South Glens Falls up by Northway now building doctor offices
- more business
- healthier food choices
- encourage church meals and town healthy get togethers
- more affordable health food choices
- affordable health care
- senior care
- communication/awareness
- better access to facilities
- more children's activities
- make it easy
- Dr. office in Salem
- Need much more research on Lyme disease prevention
- Drug addiction/alcohol programs

Q2. **What are the biggest <u>Health Issues</u> you see going on in your community?**

- Drugs
- Apathy
- EMT long waits
- Ticks
- Lyme
- Cognitive issues
- Drug use

Q3. **What are the Social Issues you see as the greatest concerns in your community?**

- Drugs
- Substandard housing
- Lack of accountability
- Lack of respect

Q4. **What Environmental Issues are of greatest concern to you?**

- discipline
- lack of discipline in homes and schools

Q6. What do you feel are the biggest Barriers that keep people from getting the healthcare they need in your community?

- Specialists not available locally
- Get a job
- No available medical
- Ignorance

Appendix J

Prioritization Methodology

- For each row the average answer weight was calculated. The numerator used was total score provided by all individuals priority setting (adding up all answers for a total) the denominator is the total number of people who answered.
- Once all focus areas were tallied, the priority scores for each separate priority were averaged to give each priority area an average overall priority score.
- Therefore, the highest priority scores would be the highest ranked priority areas. (highlighted).
- Mental health and substance abuse had the second highest priority score, but many people did not choose well-being after a discussion at the meeting regarding the criteria, sustainability, &capacity which appears to have skewed the results. This led to the categorical area Prevent communicable diseases ranking higher as a category.

ARHN PRIORITIZATION WORKSHEET

Washington County Priority Setting Novmber 2019

5 = High Feasibility, Impact or Need
3 = Medium Feasibility, Impact or Need
1 = Low Feasibility, Impact or Need
0 = Not Applicable

	NEED			FEASIBILITY			IMPACT	
	Quartile/ Severity Score (How Severe is the Problem?)	Stakeholder Survey (What is the Perceived Community Need?)	Perceived Need for Additional Resources	Is Funding Available and Sustainable?	Availability of Evidenced-based Interventions	Capacity of Stakeholders to Implement Potential Interventions	Effectiveness of Current Strategies	Are There Multiple Health Benefits?
	2.0	0.5	1.5	1.5	1.0	1.5	1.0	1.0
IMPROVE HEALTH STATUS AND REMOVE HEALTH DISPARITIES								
Health Disparities								
PROMOTE A HEALTHY AND SAFE ENVIRONMENTAL								
Injuries, Violence, and Occupational Health								
Outdoor Air Quality								
Built and Indoor Environments								
Food and Consumer Products								
Water Quality								
PREVENTING CHRONIC DISEASE								
Healthy Eating and Food Security								
Chronic Disease Preventive Care and Management								
Physical Activity								
Tobacco Prevention								
PROMOTING HEALTHY WOMEN, INFANTS, AND CHILDREN								
Maternal and Women's Health								
Perinatal and Infant Health								
Child and Adolescent Health								
Cross Cutting Healthy Women, Infants and Children								
Prevent Communicable Diseases								
Vaccine Preventable Diseases								
HIV								
Sexually Transmitted Infections (STI)								
Hepatitis C Virus (HCV)								
Antibiotic Resistance and Healthcare Associated Infections								
PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE								
Well being								
Mental and Substance Use Disorders Prevention								
OTHER INDICATORS								
Other Prevention Agenda Issues	0.50	2.00	0.67	1.00	1.00	0.67	1.00	0.67

ARHN PRIORITIZATION WORKSHEET

Washington County Priority Setting Novmber 2019

5 = High Feasibility, Impact or Need
3 = Medium Feasibility, Impact or Need
1 = Low Feasibility, Impact or Need
0 = Not Applicable

		NEED			FEASIBILITY			IMPACT	
	Priority Score	Quartile/ Severity Score (How Severe is the Problem?) 2.0	Stakeholder Survey (What is the Perceived Community Need?) 0.5	Perceived Need for Additional Resources 1.5	Is Funding Available and Sustainable? 1.5	Availability of Evidenced-based Interventions 1.0	Capacity of Stakeholders to Implement Potential Interventions 1.5	Effectiveness of Current Strategies 1.0	Are There Multiple Health Benefits? 1.0
IMPROVE HEALTH STATUS AND REMOVE HEALTH DISPARITIES									
Health Disparities	22.625	3.00	4.00	3.00	1.40	2.20	1.75	1.00	2.20
	0.00								
	0.00								
	0.00								
PROMOTE A HEALTHY AND SAFE ENVIRONMENTAL	15.51								
Injuries, Violence, and Occupational Health	6.77	0.50	0.67	0.50	0.60	1.20	0.67	0.33	1.25
Outdoor Air Quality	13.53	2.67	1.67	0.50	1.17	1.50	1.14	0.25	1.40
Built and Indoor Environments	20.35	3.00	3.00	2.00	1.60	2.20	1.33	1.00	2.25
Food and Consumer Products	20.98	2.33	2.33	2.00	2.00	2.40	2.00	1.25	2.50
Water Quality	15.92	2.00	2.33	2.00	1.20	1.60	0.50	1.00	2.60
PREVENTING CHRONIC DISEASE	28.44								
Healthy Eating and Food Security	31.40	3.00	2.67	1.67	3.29	3.88	3.75	3.33	3.80
Chronic Disease Preventive Care and Management	33.84	3.50	3.00	2.25	3.67	3.43	3.63	3.20	4.40
Physical Activity	35.21	3.50	3.33	3.00	3.33	4.29	3.57	3.00	4.40
Tobacco Prevention	41.76	4.00	4.00	3.00	4.29	4.67	5.00	4.00	4.67
PROMOTING HEALTHY WOMEN, INFANTS, AND CHILDREN	16.85								
Maternal and Women's Health	14.00	3.00	1.00	1.00	0.00	3.00	0.00	0.00	3.00
Perinatal and Infant Health	23.05	2.50	1.00	2.00	1.83	2.80	2.50	2.00	3.25
Child and Adolescent Health	25.91	3.00	3.00	2.50	2.29	2.29	2.17	2.50	3.20
Cross Cutting Healthy Women, Infants and Children	21.28	2.50	1.50	2.25	1.80	3.20	1.50	1.75	2.25
Prevent Communicable Diseases	23.42								
Vaccine Preventable Diseases	25.30	3.00	2.00	1.00	2.67	2.50	2.50	2.80	3.75
HIV	21.65	3.00	2.00	1.00	2.20	1.60	2.00	1.75	3.50
Sexually Transmitted Infections (STI)	23.05	3.00	2.00	1.00	2.60	2.40	2.00	1.75	3.50
Hepatitis C Virus (HCV)	22.90	3.00	2.00	1.00	2.60	2.00	2.00	2.00	3.50
Antibiotic Resistance and Healthcare Associated Infections	24.20	3.50	4.00	1.00	2.20	2.00	1.60	2.25	3.75
PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE	22.56								
Well being	9.00	0.00	0.00	0.00	1.00	3.00	3.00	0.00	0.00
Mental and Substance Use Disorders Prevention	36.11	4.33	3.67	3.67	3.63	4.63	2.00	2.25	4.80
OTHER INDICATORS									
Other Prevention Agenda Issues	8.4	0.50	2.00	0.67	1.00	1.00	0.67	1.00	0.67